The characteristics of kind and compassionate care during childbirth according to midwives

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PREFACE

Report outline
This report was compiled using the North West University (NWU) Manual for Master’s and Doctoral Studies (NWU, 2016:22) article format. In accordance with the guidelines, one manuscript was formulated following the instructions of the Bio Med Central (BMC) Pregnancy and Childbirth Journal. Resultantly, repetition of sections is inevitable, with some sections repeated verbatim.

The following structure will be followed:
Chapter 1: Overview of the study

Chapter 2: Literature review

Chapter 3: Article manuscript: The characteristics of kind and compassionate care during childbirth according to midwives

Chapter 4: Evaluation of the study, limitations and recommendations for future midwifery practice, research, education and policy.

The study was carried out, and written by the researcher – Samantha Salome Krausé, Open Researcher and Contributor Identification Number (ORCID), 0000-0001-8363-1040, under the supervision of the principle study leader, Professor C.S. Minnie and Professor S.K. Coetzee.

The referencing style used was the NWU Harvard style, as in The North-West University Guide (NWU: 2012), with the exception of Chapter three, where the author guidelines of the BMC Pregnancy and Childbirth Journal was followed.
ACKNOWLEDGEMENTS

I would like to express my deep gratitude and appreciation to the following people:

- To my husband, Damien Krausé, thank you for your never-ending love, support and encouragement. You are both my anchor and compass. “Love and compassion are necessities, not luxuries. Without them humanity cannot survive.” (Dalai Lama)

- To my son, Judah Krausé, thank you for being my joy and light. “Spread love everywhere you go, let no one ever come to you without leaving happier.” (Mother Theresa)

- To my Mom and Dad, Annelie and Gerhard Naus, thank you for always making sure I had the best in life and for providing me with privileges that I am still reaping the rewards from. “Kindness in words creates confidence. Kindness in thinking creates profoundness. Kindness in giving creates love.” (Lao Tzu)

- To my in-laws, Lindy and Rob Krausé, thank you for your continuous support and making the impossible possible. “A single act of kindness throws out roots in all directions, and the roots spring up and make new trees.” (Amelia Earhart).

- To my brothers Matthew and Gerard Naus (as well as my sister-in-law Nadine Naus), thank you for your encouragement and love. “No act of kindness, however small, is ever wasted.” (Aesop)

- To one of my oldest and dearest friends, Stacey Viljoen, thank you for your unceasing interest and praise. “Compassion is not a relationship between the healer and the wounded. It’s a relationship between equals. Only when we know our own darkness well can we be present with the darkness in others. Compassion becomes real when we recognize our shared humanity.” (Pema Chodron)

- To my study leader, Professor Siedine K. Coetzee, thank you for your patience and reassurance. You are an inspiration. “Educating the mind without educating the heart is no education at all.”(Aristotle)
• To the designer and principle investigator of the full study (to which mine was a sub-study) Professor C.S. Minnie, thank you for your motivation in getting this leg of the project done. “My wish for you is that you continue. Continue to be who you are, to astonish a mean world with your acts of kindness.” (Maya Angelou)

• To the ladies whom I share an office as well as a piece of my heart with – Dibolelo Lesao; Johandi Neethling; Kgomotso Mathope, Olivia Ngami and Stephani Botha, thank you for all the laughs and upliftment. “Kindness is a language that the deaf can hear and the blind can see.” (Mark Twain)

• To my colleagues at the School of Nursing Science, thank you for always teaching me something new. You are a woman amongst woman. “Everyone you meet is fighting a battle you know nothing about. Be kind. Always.”

• To the PLUME FUNDISA/NRF grant for the project: “Improving quality of midwifery care through implementation of evidence-based strategies – Promoting kind and compassionate care during childbirth of CS Minnie”. Thank you for carrying the study financially.
ABSTRACT

Background
Although compassion is considered to be of prime importance in nursing and midwifery care, there is no clear understanding of what compassionate care in childbirth entails, and how midwives’ perceive compassionate care is largely unknown. This study accordingly seeks to explore and describe the characteristics, as perceived by midwives, of kind and compassionate care during childbirth.

Methods
A qualitative descriptive inquiry was undertaken by means of a voluntary online survey, where participants were recruited via snowball sampling on the social networking site Facebook. The participants were midwives, and the unit of analysis was the received response. Participants gave written responses reporting on instances of kind and compassionate care during childbirth. The data was thematically analysed using Tesch’s eight steps to identify common themes.

Results
Ninety-eight responses from participants were analysed and three themes and 11 sub-themes emerged as dominant characteristics. Themes and sub-themes were as follows: making meaningful connections with patients (displaying good interpersonal skills, conduct based on dignity and respect, establishing trust); initiating individualised understanding of each patient (showing empathy, being patient, permitting maternal choice, promotion of advocacy, non-judgemental attitude) and action through care and support (providing emotional support, assistance through instrumental support, continuous informational support).

Conclusion
In seeking to determine what characterises compassionate care, a pivotal consideration is relationship based on trust involving a distinctive understanding of the individual patient and her individual needs. Unique to this study was the finding that participants regarded advocacy as a characteristic of compassionate midwifery care. There was also an emphasis on not judging the labouring woman, as it hindered the connected relationship created. By acting on the information gathered through connections and shared
understandings the midwife provides compassionate emotional, instrumental and informational care and support. Better understanding of how midwives perceive compassionate care could potentially improve the quality of care midwives offer during childbirth.

Keywords
Attributes, kindness, compassion, labour, birth, midwifery, perception, understanding, thematic analysis
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<table>
<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>BMC</td>
<td>Bio Med Central</td>
</tr>
<tr>
<td>FUNDISA</td>
<td>Forum of University Deans of South Africa</td>
</tr>
<tr>
<td>HREC</td>
<td>Health Research Ethics Committee</td>
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<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
</tr>
<tr>
<td>NRF</td>
<td>National Research Foundation</td>
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<td>NWU</td>
<td>North West University</td>
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<tr>
<td>ORCID</td>
<td>Open Researcher and Contributor Identification Number</td>
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<tr>
<td>POPI</td>
<td>Protection of Personal Information</td>
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<tr>
<td>SANC</td>
<td>South African Nursing Council</td>
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<td>SNS</td>
<td>Social Networking Site</td>
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<td>UN</td>
<td>United Nations</td>
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<td>WHO</td>
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CHAPTER 1:  
OVERVIEW OF THE STUDY  

1.1 Introduction  

This is a sub-study of a larger study titled “Promoting kind and compassionate care during childbirth”. The larger study is led by the principal investigator Prof CS Minnie as part of the PLUME program of the Forum of University Deans of South Africa (FUNDISA) and funded by the National Research Foundation (NRF). The findings of this sub-study will contribute towards the overall larger study goal of promoting kind and compassionate care during childbirth and improving the quality of midwifery care through implementation of evidence-based strategies.  

This chapter outlines the background and problem statement and identifies the research question, aim and objective. A general overview of the study is presented through explanation of the research design and method and indication of applicable ethical considerations.  

1.2 Background and rationale for the study  

Midwives are often the main caregivers caring for healthy women during childbirth (Brodie, 2013:1075; Feijen-de Jong et al., 2017:157; ICM, 2013:19) and have been referred to as the “backbone” of maternal and newborn care (Brodie, 2013:1075). How the midwife cares for the woman during childbirth is associated with deep personal and cultural significance for the woman herself and for her family (White Ribbon Alliance, 2011:1). Recently, however, there have been an alarming number of reports of disrespect and abuse during childbirth (Bowser & Hill, 2010:6; Freedman & Kruk, 2014:1; Goer, 2010:33-35; Honikman et al., 2015:284; Human Rights Watch, 2011; Kruger & Schoombee, 2009:84-85; White Ribbon Alliance, 2011:1-2). This has been noted by the World Health Organization (WHO) as a serious problem that needs urgent attention (WHO, 2014).  

Every women has the right to the highest attainable standard of health, which includes the right to dignified, respectful care (WHO:2016), and a recent WHO advisory on positive childbirth experience makes recommendations on how to manage and minimise
disrespect and abuse by providing compassionate care to all women (WHO, 2018:19-21, 23, 25, 32, 93, 96, 157).

Compassion is referred to in the literature in terms of adding quality to patient care (Sinclair et al., 2016a:1, 8, 10; Sinclair et al., 2016b:193). To confront the problem of disrespect, a “culture of compassionate care” has therefore been encouraged globally in nursing and midwifery care. One of the first countries to implement this on a national basis has been the United Kingdom. The guiding principles are the so-called “6 C’s”: care, compassion, courage, communication, commitment and competence (Cummings & Bennett, 2012:10, 13), originally devised for general nurses in an attempt to improve the quality of care delivered, but subsequently sifting through to midwifery practice. Largely unknown, however, is how midwives perceive compassionate care during childbirth (Ménage et al., 2017:558-560).

The term midwife signifies “a person trained to assist at childbirth” (The Pocket Oxford Dictionary, 2000:562). In the fuller internationally accepted definition pioneered by the International Confederation of Midwives (ICM) in collaboration with the WHO and the United Nations (UN), a midwife is

*a person who has successfully completed a midwifery education programme that is recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title “midwife”; and who demonstrates competency in the practice of midwifery. (ICM, 2011:1)*

As defined by the South African Nursing Council (SANC), midwifery is

*a caring profession practised by persons registered under this Act [Nursing Act 2005], which supports and assists the health care user and in particular the mother and baby, to achieve and maintain optimum health during pregnancy, all stages of labour and the puerperium. (Nursing Act, 2005:5)*

Globally, the ICM guides midwifery associations and their governments on the essential competencies for basic midwifery practice (ICM, 2013:1). Once deemed competent, the midwife may practice in whichever context is applicable: the home, the community, hospitals, clinics or health units (ICM, 2013:2). The competent midwife then works
together with women, taking full responsibility and liability for their pregnancy, labour and puerperium care (ICM, 2011:1).

The ICM (2013:19) defines competence for midwives as “a combination of knowledge, professional behaviour and specific skills that are demonstrated at a defined level of proficiency in the context of midwifery education and practice.” Seven basic obligatory competencies are set out and explained in terms of key knowledge and skills needed to be considered competent.

The seven basic competencies are in each case competency in

- social, epidemiologic and cultural context of maternal and newborn care
- pre-pregnancy care and family planning
- care during pregnancy
- care during labour and birth
- care during the postpartum period
- postnatal care of the newborn
- facilitation of abortion-related care (ICM, 2013:3-18).

The focus in the international and the national definitions of a midwife, and also the focus of midwifery associations, is clearly on the minimum cognitive and psychomotor competencies required of a midwife (Byrom & Downe: 2010:127; Fraser, 1999:105-106; ICM, 2011:1; ICM, 2013:3-18; McCourt & Pearce, 2000:149-151; Nicholls & Webb, 2006:415; Nursing Act, 2005:5). However, in the last decade midwifery has also started to focus on the affective domain in addition to the cognitive and psychomotor competencies required of a midwife (Byrom & Downe, 2010:127). A “good midwife”, so termed, is one who is competent in the cognitive, psychomotor and affective domains (Borrelli 2014, 3-5; Byrom & Downe, 2010:126; Nicholls & Webb, 2006:427). Competency in the affective domain has been described as use of soft skills such as compassion, kindness, empathy and support (Byrom & Downe, 2010:126, 130, 135; Masala-Chokwe
& Ramukumba, 2015:1; Nicholls & Webb, 2006:414,427), of which compassion is considered to be of prime importance (Sinclair et al., 2016b:194).

The term *compassion* stems from the Latin *com*, meaning together with and *pati*, meaning to suffer (Shantz, 2007:48). In this study, the definition of compassion by Sinclair et al., (2016a:6) as “a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action” will be adopted. Actions taken to alleviate suffering and needs of a person, along with deeds of kindness, will be understood as the action component in compassion (Sinclair et al., 2016a:2-3, 8, 10). Deeds of kindness will be understood as actions taken beyond the normal or routine ambit of the midwife’s care: supererogatory deeds, expressed in metaphorical terms as “going the extra mile” or “going above and beyond” (Sinclair et al., 2016a:8). Thus, *compassion and kindness* will be regarded as a single term, and in mention of compassion kindness is simultaneously assumed.

Compassion tends to be referred to in the literature along with deeds of kindness (Goetz et al., 2010:352, 354, 364; McCaffrey & McConnell, 2015:3010; McConnell, 2015:96-98) which are not obligatory and not rewarded financially (Sinclair et al., 2016a:1, 3, 6, 8). These deeds are seen as acts performed that are not usually considered part of the midwife’s regular care (Beaumont & Hollins Martin, 2016:783; Carolan, 2013:115; Sinclair et al., 2016a:8) – described by Sinclair et al. (2016a:8) as “going above and beyond”.

In a conceptual analysis conducted by Ménage et al. (2017:559) no account was found in the current body of knowledge of how compassion is perceived by midwives. Compassion was discussed as a process in midwifery care and expressed in a model based primarily on studies related to nursing and health care. The process begins with acknowledgement of suffering that stimulates emotions experienced by the midwife, motivating him/her to relieve the suffering through subsequent deeds (Ménage et al., 2017:558-560, 563).

Compassion is thus undeniably sought for in nursing and midwifery care (Burnell, 2013:180; Crawford et al., 2014:3589; Graber & Mitcham, 2004:87-88; Hall, 2013:269; Strauss et al., 2016:15). Nonetheless, there is no agreed-upon definition of compassion in the literature (Dewar et al., 2014:1738, Goetz et al., 2010:351, Sinclair et al., 2016a:1, Strauss et al., 2016:15, Way & Tracy, 2012:292) nor is there a clear understanding of
compassion in midwifery (Ménage et al., 2017:558-559). This study accordingly sought to explore and describe the characteristics of what midwives regard as kind and compassionate care during childbirth.

1.3 Problem statement

Midwives work together with women during their pregnancy, labour and puerperium stages, and global standards have been set for the minimum cognitive and psychomotor competencies required of a midwife (ICM, 2013:3-18). However, recent literature has seen new focus on the notion of the good midwife, which includes affective competencies. Competency in the affective domain has been described as the use of emotions and feelings such as compassion, kindness, empathy and support (Byrom & Downe, 2010:126, 135; Masala-Chokwe & Ramukumba, 2015:1; Nicholls & Webb, 2006:414,427) of which compassion is considered to be of prime importance (Sinclair et al., 2016b:194) and pivotal to quality nursing and midwifery care (Shantz, 2007:48; Ménage et al., 2017:558). Although researchers are exploring the term compassion in nursing (Blomberg et al., 2016:137; Downs, 2013:53; Ellis-Hill, 2011:6; Goetz et al., 2010:351; Graber & Mitcham, 2004:87; Halifax, 2011:146; McConnell, 2015:96-97; Shantz, 2007:48; Sinclair et al., 2016a:1; Sinclair et al., 2016b:193, Strauss et al., 2016:15), little is known about what constitutes compassion in midwifery (Ménage et al., 2017:558) – compassion which authors consider to be essential for improvement of midwifery care (Byrom & Downe, 2010:126, 135; Ménage et al., 2017:558-559; Nicholls & Webb, 2006:414, 427) and for reducing the incidence of disrespect and abuse (Freedman & Kruk, 2014:1-2).

From this problem statement the following research question arises:

What are the characteristics of kind and compassionate care during childbirth as perceived by midwives?

1.4 Research aim and objective

Aim of the study

To create awareness amongst midwives in regard to kind and compassionate care and contribute to promote kind and compassionate care by midwives during childbirth, for ultimate improvement of the quality of care rendered.
Research objective

To explore and describe how midwives perceive the characteristics of kind and compassionate care during childbirth.

1.5 Central theoretical argument

The central theoretical argument of this study is that exploring and describing the characteristics of kind and compassionate care during childbirth as perceived by midwives will create awareness and contribute to promote kind and compassionate caregiving by midwives during childbirth, thereby improving the quality of care and reducing the incidence of disrespect and abuse during childbirth.

1.6 Research design

A qualitative descriptive research design was chosen as best fitting the research problem of deficit in the understanding of what constitutes kind and compassionate care in midwifery, calling therefore for exploration and description (Creswell, 2009:18). This type of design suits description of accounts from practice to develop meaningful understanding of an ill-explored concept (Sandelowski, 1997:128).

1.7 Research methods

The research methods for this study as briefly outlined below include population and sampling, data collection, data analysis and ethical considerations.

1.7.1 Population

The target population was midwives practicing in South Africa and elsewhere. The units of analysis were the responses from each midwife, not the midwives themselves.

1.7.2 Sampling method

Snowball sampling was done via Facebook groups. Facebook was chosen as the social networking site (SNS) best suited for recruitment of potential participants in view of its size, features, intensive use, and continuing growth (Bhutta, 2012:57). SNS's offer new ways for researchers to conduct studies quickly and cost-effectively, particularly in constructing snowball samples for exploratory work (Bhutta, 2012:59; Murray & Fisher, 2002:10).
A Facebook page was created and named “Promoting kind and compassionate care during childbirth” (see Addendum A). The target population was recruited through midwife-based groups and pages on Facebook using the search words “midwife” and “childbirth”.

A notice addressed to interested midwives was posted on group pages identified as midwife-based, inviting them to participate in the proposed study via a link to the study’s Facebook page (see Addendum B). Typically, each Facebook user has their own network of friends, family and Facebook groups (virtual communities linking people with common interests). Interested midwives were invited to like and share the study’s Facebook page; this increased the likelihood of other midwives taking cognizance of the study, thereby propelling the snowball sampling process.

1.7.3 Sample

The participant units in the study were completed responses from midwives who met the inclusion criteria set out in Table 1-1. The researcher considered a response as completed when all 10 of the questions were answered without any having been skipped. As the objective of this study was explore and describe how midwives perceive the characteristics of kind and compassionate care during childbirth, no limit was placed on the number of responses received. If there were more than one incident midwives wished to report, they were invited to do so, since any incident profound enough to make an impact on the midwife was deemed relevant. There were no exclusion criteria. Unrelated and incomplete responses and where participants did not answer the open-ended question were cleaned before data analysis.

The researcher could not predict a specific sample size due to the exploratory nature of the research question and the unpredictability of the number of replies. Hill (1998:4) indicates a wide range of possibilities (from 30 to 500) for recommended sample size in an online survey. It was accordingly estimated that the sample size would be around 100, in view of the qualitative nature of the study. Number of completed responses ultimately received was 98. In an online survey reported by Bhutta (2012:67-68), the majority of the responses were received within the first few days following the survey launch. However, in this study less than 50 responses were received within the first month and a second invitation was therefore posted on the Facebook page. A further 48 responses were then
received in the subsequent two months. As previously explained, no limit was placed on the number of responses that could be submitted by each participant.

Table 1-1: Inclusion & exclusion criteria with rationale

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives who have experience in assisting women during childbirth</td>
<td>No time limit is placed on experience, as any life event that has made an impression on the midwife will be relevant.</td>
</tr>
<tr>
<td>Midwives who have internet access</td>
<td>Recruitment through Facebook group.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>None applied</td>
<td></td>
</tr>
</tbody>
</table>

1.7.4 Data collection

The survey was open for 3 months for data collection from 13 December 2016 to 13 March 2017. The Facebook page contained a direct link to the SurveyMonkey electronic platform used for the self-administered survey was hosted. SurveyMonkey was chosen as the online site to collect and store data in view of favourable features it offers such as affordability, easy format and possibility to set up the survey as desired (Survey Monkey, 2018:online). Electronic surveys have been reported as equivalent to paper-based surveys in terms of internal reliability and completion rates (Denscombe, 2006:246; Joubert & Kriek, 2009:78). The benefits of online surveys are that they save time, are cost-effective, and can be accessed quickly by people with shared characteristics from widely separated geographical locations (Callegaro et al., 2015:18-23; Wright, 2005).

The self-administered survey consisted of a demographic section with five closed-ended questions and three open-ended questions (see Appendix A). The closed-ended questions (with the options for choice of one standard answer indicated in brackets) were as follows:

- What is your gender? (male or female)
- Where do you practice midwifery? (rural area or urban area)
• In which facility do you practice midwifery? (state hospital, private hospital, community health centre, private practice that is midwife-lead or other)

• How many years’ experience do you have working as a midwife? (1-5 years, 5-10 years, 10-20 years, 20-30 years or 30 plus years)

• Is this the first time you are answering the survey? (yes or no).

Concise instructions were given, followed by the three open-ended questions. Two were explicitly phrased:

• Please write a paragraph about an instance in which you saw or experienced kind and compassionate care during childbirth.

• List five words that you associate with kind and compassionate maternity care.

The third made provision for participants to contribute any additional comments. Once the survey was complete, the participant was asked to click on the “submit” button.

According to Callegaro et al., (2015:69), an advantage of open-ended questions is that participants have an opportunity to re-tell a life event that made an impact on them in as much detail as needed, thereby revealing how the concept is perceived (in this case, by the midwife). Closed-ended questions, on the other hand, do not provide much insight. The disadvantage of open-ended questions is that it might be a cognitive strain to answer them; they were accordingly kept to a minimum in this study (Callegaro et al., 2015:69).

1.7.5 Data analysis

Thematic analysis was the most appropriate means to analyse this data set, as the objective of the study was to explore and describe the characteristics of a specific concept. Braun and Clarke (2006:79) explain that thematic analysis is “a method of identifying, analysing and reporting patterns within data.” Patterns can also be referred to as themes. This makes it possible to identify a common train of thought in the responses received from the participants (Morse & Field, 1995:139, Vaismoradi et al., 2013:400).

The data analysis took place as follows: the data were transferred to an Excel spreadsheet and then imported into the qualitative research program Atlas.ti 8, which was
used to process the large amount of data into a smaller set of easily readable interpreted themes (Burns & Grove, 2009). The data were managed and arranged by numbers according to the sequence in which responses were received. As this was an anonymous survey, there were no other identifiable data.

Thematic analysis was carried out according to Tesch’s eight steps as explained by Creswell (2009:186). The data set was read over to obtain a general idea of what was said. Next, it was looked at in greater detail to begin the coding process. Coding is defined by Creswell (2009:186) as the process of taking a large amount of data and breaking up into smaller sections before attaching meaning to it. These smaller sections were named following the open coding process of giving labels or renaming sections of the data set to find and categorise shared meanings (Morse & Field, 1995:140). The data set was read through again to get an idea of what participants had to say. A handful of the most interesting responses from participants were identified and read through several times to determine their fundamental meaning. A list of topics surfaced that had been brought up several times by different participants. New categories originated from reading through the responses from the participants again. These were then refined and grouped according to similar meanings, resulting in a list of final categories – labelled as themes – which had come to light (Creswell, 2009:186).

1.7.6 Trustworthiness

The four fundamental epistemological standards listed by Lincoln and Guba (1985) were applied to ensure the trustworthiness of this qualitative study. Theoretical validity was provided by conceptualisation of the central concepts described in the study (Botes, 2003).

Prolonged engagement in the field of midwifery and in the collection and analysis of data, and peer debriefing with the principle investigator and co-supervisor, enhanced the credibility of the study findings. Transferability was strengthened by providing a thorough account of the research process applied in the study and by analysing all data entries even after data saturation was reached. The dependability of the study was enhanced through review, approval and monitoring from the applicable scientific committees and study leaders associated with this study. A co-coder (a Honours Psychology student) was assigned to thematically analyse the data set. The codes were subsequently worked on
individually. The researcher and the co-coder obtained inter-coder agreement regarding the open codes (Creswell, 2009:187). The researcher declares a non-biased approach to the study, increasing the confirmability of the results.

1.7.7 Ethical considerations

Ethical approval was granted by the INSINQ Scientific Committee and the Health Research Ethics Committee (HREC) of North-West University (NWU) for the overall project: Promoting kind and compassionate care during childbirth. This sub-study addresses the second objective, namely: “To explore and describe characteristics of kind and compassionate care according to midwives” (NWU-00072-16-A1 – see Appendix C). As the study took place online, no further legal authorization or goodwill consent was necessary.

1.7.7.1 Informed consent

The link to SurveyMonkey took potential participants to an introduction page which was simultaneously utilized as the informed consent (see Appendix B). The introductory page stipulated the criteria that the participants should meet, what was expected from the participants, the questions that the participant was expected to answer, the risks and benefits of the study, the fact that participants may withdraw from the study at any time, and ended with a statement that multiple submissions will be accepted. The participant could withdraw from the study at any time by exiting the SurveyMonkey page. Potential participant who agreed with the above-stated conditions were requested to click on a specified button to complete the online survey.

1.7.7.2 Anonymity and confidentiality

Anonymity was ensured as no names or contact details were requested. Theoretically, through a default option in SurveyMonkey (2018:online), the computer from which the survey was completed could however be identified by the IP address; to prevent this, the anonymous response option was activated. The completed surveys were identified in the sequence in which participants submitted them. Anonymity and confidentiality was thus not compromised (Buchanan & Hvizdak, 2009:43).
1.7.7.3 Risks and benefits

The estimated level of risk for the participants was estimated to be minimal, as the focus of the study was on positive experiences. A low risk of psychological discomfort was identified, as the participant might be reminded of their own or witnessed negative childbirth experiences. In this instance, the participant was encouraged to contact the researcher via email, and psychological support would be arranged by the researcher. Such an incident did not occur.

The survey was not time-consuming, as the expected completion time was 15 to 30 minutes. There was no direct benefit for the participant; benefit was indirect in ultimately contributing to the improvement of practice. There was no remuneration or reimbursement for the participant.

1.7.7.4 Data management and security

The researcher, the supervisor’s and the co-coder were the only people that had access to the anonymous data set. The researcher ensured that the electronic data would remain confidential (Protection of Personal Information [POPI] Act 4 of 2013) by password protecting all electronic equipment storing the data set. The electronic copies of the data will be stored on an external storage device post data analysis, in a locked cupboard in the principle investigator’s office. This includes any hard copies of the data set. The electronic and hard copies will be destroyed after five years.

1.8 Conclusion

This concludes the overview and introduction for the study “The characteristics of kind and compassionate care during childbirth according to midwives”. The background and problem statement were discussed, the research question, aims and objectives were identified, the research design, method and analysis were described, and the applicable trustworthiness and ethical considerations were highlighted.
CHAPTER 2:
LITERATURE REVIEW

2.1 Introduction

Chapter one presented an overview of the study providing background and rationale, identified the research aim and objective, discussed the research design and method and identified the ethical considerations.

In this chapter, a literature review is provided to indicate what is currently known about the characteristics of kind and compassionate care during child birth as perceived to midwives. As stated by Botma et al. (2010:63-64), the aim of a literature review is to assess what is presently known about a phenomenon and present a frame of reference that shows how the findings of the study will contribute towards the existing body of knowledge.

A disturbing phenomenon noted in Chapter one is the occurrence of disrespect and abuse during childbirth (Bowser & Hill, 2010:6; Freedman & Kruk, 2014:1; Goer, 2010:33-35; Honikman et al., 2015:284; Human Rights Watch, 2011; Kruger & Schoombee, 2009:84-85; White Ribbon Alliance, 2011:1-2). Documenting this as a pressing problem, the WHO stresses that every woman has the right to the highest attainable standard of health (WHO:2016), including the right to dignified, respectful care and advises that providing compassionate care to all women should ultimately reduce the incidence of disrespect and abuse (WHO, 2018:19-21, 23, 25, 32, 93, 96, 157).

As highlighted in Chapter one, international standards have been set for the minimum cognitive and psychomotor competencies required of a midwife (ICM, 2013:3-18). The recent focus in the literature on the concept of the “good midwife”, brings in the issue of affective competencies. Competency in the affective domain has been reported to include the effects of emotions and feelings such as compassion, kindness, empathy and support (Byrom & Downe, 2010:126, 135; Masala-Chokwe & Ramukumba, 2015:1; Nicholls & Webb, 2006:414,427) of which compassion is considered of prime importance (Sinclair et al., 2016b:194) and pivotal to quality nursing and midwifery care (Ménage et al., 2017:558; Shantz, 2007:48).
Although researchers have been exploring the significance of compassion in nursing (Blomberg et al., 2016:137; Downs, 2013:53; Ellis-Hill, 2011:6; Goetz et al., 2010:351; Graber & Mitcham, 2004:87; Halifax, 2011:146; McConnell, 2015:96-97; Shantz, 2007:48; Sinclair et al., 2016a:1; Sinclair et al., 2016b:193, Strauß et al., 2016:15), little is known about what constitutes compassion in midwifery (Ménage et al., 2017:558), which is regarded as a crucial factor in improving midwifery care (Byrom & Downe, 2010:126, 135; Ménage et al., 2017:558-559; Nicholls & Webb, 2006:414, 427) and in reducing the prevalence of disrespect and abuse (Freedman & Kruk, 2014:1-2).

2.2 Search strategy

To find relevant literature addressing the research problem, the following electronic databases was searched: EBSCO Host; Academic Search Premier; CINAHL; ERIC; Health Source: Nursing/Academic Edition; MasterFile Premier; MEDLINE; Pre-CINAHL; PsychINFO; Cochrane Library; SociINDEX with Full Text; Humanities International Complete; Academic Search Complete; Education Research Complete; Science Direct; SAePublications and PubMed Central. Google and Google Scholar were also searched using the advanced option.

Working in conjunction with the subject librarian at the NWU Potchefstroom Campus, the following search words were identified: (midwife* OR maternity care OR nurs*) AND (childbirth OR labour OR care); AND (characteristics OR attributes); AND (kind* OR compassion*). Synonyms for compassion were also searched, such as empathy and sympathy.

2.3 Sympathy, empathy and compassion

Nursing and midwifery literature frequently refers indistinguishably to sympathy, empathy and compassion (Goberna-Tricas et al., 2011:231; Goetz et al., 2010:360; von Dietze & Orb, 2000:116; Shantz, 2007:49) despite these being three distinct concepts (Beaumont & Hollins Martin, 2016:784; Blomberg et al., 2016:138; Sinclair et al., 2016a:1-2; Sinclair et al., 2016b:193; Way & Tracy, 2012:308).

In the reviewed literature, sympathy was collectively defined as feeling for another (Beaumont & Hollins Martin, 2016:784; Ménage et al., 2017:562; Sinclair et al., 2016b:193). Empathy was jointly defined as feeling with another (Beaumont & Hollins
Martin, 2016:784; Goetz et al., 2010:351), and as understanding the feelings of another (Ménage et al., 2017:562). Compassion was defined as feeling together (Dewar, 2013:61; Maben et al., 2009:9), feeling with another (McCaffery & McConnell, 2015:3010), and subsequently performing a deed or deeds (Beaumont & Hollins Martin, 2016:783) to provide relief for suffering or pain (Goetz et al., 2010:351; McCaffery & McConnell, 2015:3010; Ménage et al., 2017:562).

Sinclair et al. (2016a:6) set out to define sympathy, empathy and compassion based on the way in which the patient perceived the nurse’s reaction to their discomfort. Sympathy was described as being a sorrowful reaction, empathy was found to be an emotional reaction (Sinclair et al., 2016a:6), and compassion was explained as a “virtuous” reaction towards another’s anguish (Sinclair et al., 2016b:193). It was further pointed out that sympathy is undesirable and non-beneficial to patients due to minimal insight (Sinclair et al., 2016a:4, 6, 9; Way & Tracy, 2012:307-308) and understanding as to what matters to the patient (Dewar et al., 2014:1743-1744).

Empathy is thought of as the basis for compassion (McCaffery & McConnell, 2015:3012), as it involves feeling with another (Halifax, 2011:146; Sinclair et al., 2016a:4, 9). However, it is frequently remarked that compassion differs from empathy in view of the activities carried out (Goetz et al., 2010:351; McCaffery & McConnell, 2015:3009; Ménage et al., 2017:562; Sinclair et al., 2016a:6, 8-9; Sinclair et al., 2016b:193) in an attempt to alleviate discomfort (Beaumont & Hollins Martin, 2016:783; Dewar & Nolan, 2013:2; Goetz et al., 2010:351; Gustin & Wagner, 2012:2; McCaffery & McConnell, 2015:3008, 3013; Ménage et al., 2017:562; Papadopoulos et al., 2017:289; Shantz, 2007:51-52; Sinclair et al., 2016a:1-4; Sinclair et al., 2016b:193, 197; Straughair 2012a:161; Strauss et al., 2016:15). Way and Tracy (2012:308) state that empathy and sympathy are feeling states. Conversely, compassion goes beyond the feeling state to an action state (Halifax, 2011:146; Sinclair et al., 2016a:3, 6, 8), manifested in deeds of displaying kindness (Sinclair et al., 2016a:1, 3, 6, 8; Sinclair et al., 2016b:197). Compassion appears to be favoured amongst the three concepts (Blomberg et al., 2016:138; Graber & Mitcham, 2004:87; Sinclair et al., 2016a:1, 8; Sinclair et al., 2016b:193). This is supported by Graber and Mitcham (2004:87) along with Way and Tracy (2012:306), as compassion is believed to be preferred by patients due to the deeds of kindness performed.
2.4 Kindness and compassion

Ménage et al. (2017:562) define kindness in a concept analysis as “the quality of being generous, considerate, friendly and deliberately doing good to others”. As stated in Chapter one, compassion tends to be referred to in the literature along with deeds of kindness (Goetz et al., 2010:352, 354, 364; McCaffrey & McConnell, 2015:3010; McConnell, 2015:96-98) that are not compulsory or monetarily remunerated (Sinclair et al., 2016a:1, 3, 6, 8). The deeds are considered to be based on a kind nature, as the acts performed are not usually reckoned as part of the midwife’s regular care (Beaumont & Hollins Martin, 2016:783; Carolan, 2013:115; Sinclair et al., 2016a:8; Sinclair et al., 2016b:197). The two terms will therefore be merged in this study with kind and compassionate regarded as a single concept.

2.5 Characteristics of compassion

Compassion has been cited as possibly the most highly valued attribute in nursing and midwifery care (Burnell, 2009:319; McCaffrey & McConnell, 2015:3013; Shantz, 2007:48) and is widely recognised as its core element (Dewar & Christley, 2013:46; Maben et al., 2009:9; McCaffrey & McConnell, 2015:3006, 3012, 3013; Strauss et al., 2016:15; von Dietze & Orb, 2000:116; Waugh et al., 2014:1190). Yet how compassion manifests itself when providing care is poorly understood (Brown et al., 2014:384, 387; Dewar et al., 2014:1739; Fry et al., 2013:1; Graber & Mitcham, 2004:88; McCaffrey & McConnell, 2015:3006, 3014; Sinclair et al., 2016b:194; von Dietze & Orb, 2000:116; Waugh & Donaldson, 2016:22).

Burnell (2013:180) describes compassion as a constituent of nursing excellence. Moreover, compassion is seen as a vital component for achieving quality nursing and midwifery care (Black, 2008:70; Blomberg et al., 2016:138; Brown et al., 2014:384; Cleary et al., 2015:536; Cummings & Bennett, 2012:13; Fry et al., 2013: 1; Larson et al., 2015:1; Sinclair et al., 2016b:193; Straughair, 2012a:160; Sturgeon, 2010:1047,1050) and it has is furthermore been proposed that more compassion is needed among its practitioners (Crawford et al., 2014:3589, 3590; Dewar & Christley, 2013:47; Ellis-Hill, 2011:6; McCaffery & McConnell, 2015:3012; Taylor, 2015:352).

Nurses and midwives perform a challenging job, generally, moreover, in difficult situations (Sturgeon, 2008:43; Sturgeon, 2010:1050). According to Sinclair et al. (2016b:202), the
characteristics of kind and compassionate care will differ, depending on the specific individuals in practice and the practice setting. This is argued as being due to the subjective character of kind and compassionate care (Dewar, 2013:61; Goetz et al., 2010:351; Straughair, 2012b:239; Papadopoulos et al., 2017:291). Way and Tracy (2012:309) affirm that “compassion is in your heart, not your head.” McCaffery and McConnell (2015:3007) aver, in metaphorical terms, that compassion is the genuine heart of nursing. Identifying the exact characteristics of compassion is thus a challenge. Ménage et al. (2017:559) have noted that no studies on what compassion means in midwifery care are to be found in the literature.

2.6 The process of compassion

Compassion is described in the literature as a process. Authors agree that compassion usually consists of three phases, beginning with recognising discomfort in others (Dewar, 2013:61; McCaffery & McConnell, 2015:3009; Strauss et al., 2016:15; Way & Tracy, 2012:300), followed by a desire to ease it (Beaumont & Hollins Martin, 2016:784; Dewar & Nolan, 2013:2-3; McCaffery & McConnell, 2015: 3012-3013, 3010; Strauss et al., 2016:15) and concluding with a functional response or action (Strauss et al., 2016:15; Way & Tracy, 2012:300) – the action being constituted by deeds of a kind nature (Sinclair et al., 2016a:1, 3, 6, 8; Sinclair et al., 2016b:197).

In an empirical research study, Sinclair et al. (2016b) identify seven phases in the process of compassion. The first phase they refer to as virtues, in which the practitioner is described as kind and caring (Sinclair et al., 2016b:197, 199). Similarly, Curtis (2013:746, 748) makes reference to there being a goodness about the practitioner. Blomberg et al. (2016:139) link compassion with displaying wisdom, humanity, love and empathy, echoing the description of virtues by Sinclair et al., (2016b:197, 199). Straughair (2012a:160-161) observes that the concept of compassion is based on devout ideals similar to those documented in the Christian and Buddhist religions. This righteous nature of compassion is based on principles of integrity, honesty and purity (McCaffery & McConnell, 2015:3006 - 3008, 3010 - 3011, 3013; von Dietze & Orb, 2000:116).

The second phase, relational space, relates to active involvement in caring, shown by understanding and recognising each patient (Sinclair et al., 2016b:199, 202). This is supported by Dewar et al. (2014:1741-1742, 1744-1745) and referred to as “relationship
centred care” (Dewar et al. 2014:1741). Burnell (2009:319) makes reference to a real connection between the practitioner and the patient. This, according to Gustin and Wagner (2012:8), takes place when the patient and the practitioner make themselves equally subject to feeling vulnerable.

The third phase, _virtuous response_, signifies intentionally becoming accustomed to the patient and recognising matters of great importance to each individual (Sinclair et al., 2016a:8-9; Sinclair et al., 2016b:193, 195-197). This is done through display of genuineness, love, openness, honest, authenticity, care, understanding, tolerance, and acceptance (Sinclair et al., 2016b:197). Ideal care should protect from harm and result in successful recovery.

The fourth phase, _seeking understanding_, is described as searching for insight into the patient and his or her key requirements (Sinclair et al., 2016a:1-4, 6-9; Sinclair et al., 2016b:193-196, 198, 200, 202). Graber and Mitcham (2004:88) state that correct regard of the patient and his or her current situation generates compassion. McCaffery and McConnell (2015:3011) refer to the circumstantial nature of compassion in which each situation presents possibility to apply a unique approach; hence the importance of searching for individualised understanding for each patient.

The fifth phase, _relational communicating_, is described as being demonstrated by deeds (displayed through real actions that are kind), affective nature (expressed through emotions and mindful approach), attitude (revealed through non-verbal body language, and tone used) and participation (shown by listening, two-way communication that is courteous and encouraging) (Sinclair et al., 2016b:196-199, 200, 202). Compassion implies having an affective nature and a deeds-based character (Beaumont & Hollins Martin, 2016:783; Cleary et al., 2015:563; Goetz et al., 2010:351; McCaffery & McConnell, 2015:3008-3009, 3013; McConnell, 2015:96), shown by deeds of kindness to others (Beaumont & Hollins Martin, 2016:783; Carolan, 2013:115; Sinclair et al., 2016a:8; Sinclair et al., 2016b:196-197) and to oneself (Beaumont & Hollins Martin, 2016:785). Way and Tracy (2012:310) support the notion that compassion is an assembly of deeds that is built through communicating. Examples of such deeds put forward by Graber and Mitcham (2004:89) are facial expressions such as a smile, and a warm manner of speaking. Cummings and Bennett (2012:13) and Black (2008:71) also emphasize the
importance of listening. Black (2008:71) advises practitioners not to rush when they speak to their patients, as this helps to create a trusting relationship.

The sixth phase, *attending to needs*, is outlined as efforts to meet the requests of the patient promptly, with no hesitation shown (Sinclair *et al*., 2016b:197-200). Responses or activities carried out in an attempt to alleviate discomfort show the deeds-based character of compassion (Beaumont & Hollins Martin, 2016:783; Dewar & Nolan, 2013:2; Goetz *et al*., 2010:351; Gustin & Wagner, 2012:2; McCaffery & McConnell, 2015:3008, 3013; Ménage *et al*., 2017:562; Papadopoulos *et al*., 2017: 289; Shantz, 2007:51-52; Sinclair *et al*., 2016a:6-9; Sinclair *et al*., 2016b:193, 195-199, 200, 202; Straughair 2012a:161; Strauss *et al*., 2016:15). Sinclair *et al*. (2016a:1, 3, 6, 8, 10) add the qualification that such deeds of kindness are not obligatory and not rewarded financially. Way and Tracy, (2012:306) refer to a further type of compassionate deed not previously noted in the literature which they refer to as *strategic inaction* – when the practitioner takes a moment to stand back and do nothing, simply allowing leeway to just be.


### 2.7 Research on compassion in nursing fields

Most of the research investigating compassion has been done in the context of nursing fields and an outline will be given here of what is known from these studies

A recent international online survey study undertaken by Papadopoulos *et al*. (2017:286) explored differences and similarities in the perception and display of compassion in nursing praxis. The survey spanned 15 countries with a total population of 1,323 nurses. A range of questions were asked relating to compassion in nursing practice. The data uncovered several themes in relation to the “conscious and intentional nature of compassion”. This was described as spending time with patients and with their families by “going the extra mile” or “giving of oneself”. Examples were given of nursing staff working beyond contracted hours to provide compassionate care (Papadopoulos *et al*., 2017:289-290). The nurses’ presence was also emphasized, with particular reference to
the intentional nature of the presence (Papadopoulos et al., 2017:291, 293). Compassionate care was also noted as being based on “individuality/personalisation” with some participants referring to being non-judgemental when providing compassionate care (Gustin & Wagner, 2012:8).

Crawford et al. (2014:3591) conducted a narrative review to investigate compassion in health care from an organisational perspective, based on the rise in demand for compassionate care. A “compassionate mentality” was understood to be gentle, warm, loving, affectionate, caring, sensitive, helpful, considerate, sympathetic, comforting, reassuring, calming, open, concerned, empathetic, friendly, tolerant, patient, supportive, encouraging, non-judgemental, understanding, giving, soothing, validating, respectful and attentive (Crawford et al., 2014:3592).

The next sections discuss the study of compassion in specific nursing specialisations.

2.7.1 Elderly care

Dewar and Nolan (2013:1) conducted a study outlining compassion in the conditions of acute care for the elderly. The study established that compassion is considered to be of prime importance in quality care for patients. Three paramount characteristics emerged, involving concepts such as emotional support, empathy and exceptional communication with the patient and the family. It was emphasised that empathy was fundamental in creating connections (Dewar & Nolan, 2013:2-3). Similarly, Dewar et al., (2014:1742-1743) found that forging emotional connections and being appreciative were seen as vital elements in providing compassionate care to patients. Burnell (2013:180) adds that these connections need to be significant to have positive impact. This enables individualised understanding of the patient and their accompanying support system (Dewar & Nolan, 2013:2-3).

A qualitative study by van der Cingel (2001:672-685) concentrated on understanding the benefits of compassion in long-term care for the elderly. Seven dimensions of compassion emerged: attentiveness, listening, confronting, involvement, helping, presence, and understanding (van der Cingel, 2011:676). Furthermore, it was pointed out that the family should form part of the decision-making process.
Dewar et al. (2014:1738-1747) also focused on elderly care using an appreciative inquiry to identify good compassionate care in ward settings with a focus on emotional connections. Seven C’s were summarised as a model of compassionate relationship-centred care: compromising, courageous, considerate, curious, celebratory, collaborative and connecting.

2.7.2 Medical-surgical care

A qualitative descriptive study by Kret (2011:29-36) explored the qualities that a compassionate nurse should possess, according to medical-surgical patients. It was found that attentiveness and caring were the qualities most sought after from a kind and compassionate nurse.

Graber and Mitcham (2004:87) used a phenomenological approach to explore the relationship between kind and compassionate practitioners and patients admitted to hospital. Twenty-four hospital clinicians were interviewed to determine what compassionate practitioners do to form relationship with their patients. It was found that compassionate practitioners develop close, affectionate relationships with patients (Graber & Mitcham, 2004:87).

2.7.3 Emergency care

Fry et al. (2013:1) conducted an investigation in Australia among emergency care nurses who had a post-basic speciality qualification on what is needed to provide patients with compassionate care. It was found that nurses who were able to quickly build a therapeutic relationship with their patients effortlessly displayed compassionate caring. Communication by verbal and non-verbal means is essential in showing kind and compassionate caring (Fry et al., 2013:14, Graber & Mitcham, 2004:89). Verbal communication was specifically found to be simple communication employing basic etiquettes such as introducing themselves (Graber & Mitcham, 2004:89). Non-verbal communication was identified as smiling, touch, and eye contact (Fry et al., 2013:14). The study concluded that compassionate caring involves an intricate mix between clinical skills and good interpersonal relationships (Fry et al., 2013:17).
2.8 Compassion in midwifery

Ménage et al. (2017:559) argue that although nursing and midwifery bear many similarities, they are essentially divided by registration and practice within the profession at large. Scientific exploration of compassion within the field of midwifery is lacking (Ménage et al., 2017:559).

Little is known about what constitutes compassion in midwifery (Ménage et al., 2017:558-562), which, according to various authors, is essential for improvement in midwifery care (Byrom & Downe, 2010:126, 135; Ménage et al., 2017:558-559; Nicholls & Webb, 2006:414, 427). To date, few studies have focused on the characteristics of compassion in practice as perceived by midwives.

It is clear that the international, national and nursing association definitions of a midwife focus worldwide on the minimum cognitive and psychomotor competencies required of a midwife (Byrom & Downe: 2010:127; Fraser, 1999:105-106; ICM, 2011:1; ICM, 2013:3-18; McCourt & Pearce, 2000:149-151; Nicholls & Webb, 2006:415; Nursing Act, 2005:5). There is very little mention of the affective competencies required of a midwife.

Compassion in midwifery is a relatively new concept (Goberna-Tricas et al., 2011:31; Hall, 2013:269; Ménage et al., 2017:558, 560) as opposed to compassion in nursing (Burnell, 2013:180; Crawford et al., 2014:2589; Dewar et al., 2014:1739; Goetz et al., 2010:351; Papadopoulos et al., 2017:286; McCaffery & McConnell, 2015:3007, 3013; Shantz, 2007:48; Strauss et al., 2016:15; Sturgeon, 2008:43; Taylor, 2015:352; van der Cingel, 2011: 672; Waugh & Donaldson, 2016:22). There is wide consensus that compassion is needed in midwifery (Butler et al., 2008:260; Byrom & Downe, 2010:126-127, 130; Feijen-de Jong et al., 2017:160; Masala-Chokwe & Ramukumba, 2015:7; Ménage et al., 2017:559; Nicholls & Webb, 2006:427; Waugh et al., 2014:1190-1195), but no accounts of how it is exhibited (Goberna-Tricas et al., 2011:31; Hall, 2013:269; Ménage et al., 2017:558-559).

A conceptual analysis by Ménage et al. (2017:559) reported that nothing is to be found in the body of knowledge indicating how compassion is perceived in midwifery. The study conclusively defined compassion as a process in midwifery care, following a model predominantly based on nursing and health care related studies. This process begins with the cognisance of suffering, prompting emotions experienced by the midwife that
motivates him/her to relieve the suffering through deeds (Ménage et al., 2017:558-560, 563) based on kindness (Beaumont & Hollins Martin, 2016:783; Carolan, 2013:115; Sinclair et al., 2016a:8; Sinclair et al., 2016b:197). The affective nature of compassion is highlighted by Ménage et al. (2017:558), who note in addition the importance of kinship and connectedness established in the practitioner/patient relationship, coupled with determination to support and encourage women.

Currently there is little mention of compassion in international instructional documentation on midwifery (ICM, 2011:1; ICM, 2013:1-2). It has been suggested that compassion be added as a core competency in nursing and midwifery care (Butler et al., 2008:260; Cummings & Bennett, 2012:13; Dewar & Nolan, 2013:9; Sinclair et al., 2016b:194). The absence in contemporary documents of discussion on compassion as a concept is attributed by Straughair (2012a:163) to the progressive focus in recent decades on cognitive and psychomotor skills, with minimal attention to affective and attitudinal aspects.

Although compassion is not explicitly mentioned in the core documents of the International Confederation of Midwives (ICM), it is implied in the documents like the philosophy and model of care (ICM, 2014), the definition of a midwife (ICM, 2011) and the code of ethics (ICM, 2008). The essential competencies of basic midwifery practice (ICM, 2013) include aspects such as partnership with women to promote self-care, respect for human dignity and advocacy for women so that their voices are heard.

Butler et al. (2008:268) stress that essential competencies in midwifery should incorporate the particular characteristics required of a midwife. Butler et al. (2008:260) add that compassion as an essential competency should include positive attitude, shown by being caring and kind as the affective component. Masala-Chokwe and Ramukumba, (2015:1, 2, 7) concur, pointing out that compassion in the absence of competence is futile. Larson et al. (2015:2, 4), support the notion that midwives need to be competent as well as being kind and compassionate.

The WHO (2015:48) states that all women have the right to favourable and good care, with practitioners treating all women with kindness and compassion (WHO, 2018:25, 32); terms such as courtesy, respect, understanding and preservation of dignity feature in the statement. In the latest recommendations (WHO, 2018:25) compassion is discussed in
the context of effective communication skills and companionship during childbirth for creating a positive birth experience. Good quality care is provided through a mix of the best skills and affective component (Larson et al., 2015:2; Masala-Chokwe & Ramukumba, 2015:1; Straughair 2012a:160, 162), specifically in the attitude of the practitioner (Tunçalp et al., 2015:1046-1047), shown by kindness and compassion (Ménage et al., 2017:559).

It is known that midwives practice under high levels of stress (Beaumont & Hollins Martin, 2016:784). This creates a problem when attempting to maintain compassion over long periods of time (Beaumont & Hollins Martin, 2016:777). Midwives are the primary practitioners that care for women during childbirth (Brodie, 2013:1075; Feijen-de Jong et al., 2017:157; ICM, 2013:19). Globally sought after (Brodie, 2013:1075) they need nonetheless, in addition to meeting the minimum requirements of competency, also to be “good midwives” who practice with kindness and compassion (Brodie, 2013:1075; Byrom & Downe, 2010:126-137; Nicholls & Webb, 2006:427).

2.9 The “good midwife”

As discussed in Chapter one, “good midwife” is a term often applied to a midwife who is competent within the cognitive, psychomotor and affective domain (Borreli 2014: 3-5; Byrom & Downe, 2010:126; Feijen-de Jong et al., 2017:160; Nicholls & Webb, 2006:414). A “good midwife” strives for a physiological approach to birth (Feijen-de Jong et al., 2017:157-158, 160-161), while childbirth itself is typically seen as series of orderly actions that results in a transformative experience (Jacinto & Buckey, 2013:11, Ménage et al., 2017:559).

A “good midwife” meets the essential competencies required in terms of cognitive and psychomotor skills, in addition to displaying a well-developed affective component (Carolan, 2011:503; Carolan, 2013:115). In the literature the cognitive competencies are synonymous with intellectual competencies (Byrom & Downe, 2010:127) and possessing adequate knowledge (Nicholls & Webb, 2006:414). The psychomotor competencies are described in terms of the skill needed to practice as a midwife (Nicholls & Webb, 2006:414) and are collectively referred to as “skilled competence” by Byrom and Downe (2010:129).
The affective competency is explained by Byrom and Downe (2010:126, 130-131,135) as “emotional intelligence” and is believed to promote excellence (Borrelli, 2014:4). This refers to personality traits shown in the midwife, with specific mention of being “approachable” and “adaptable” (Byrom & Downe, 2010:132). Caring personality required of a midwife was explained in terms such as “supportive”, “enthusiastic”, “understanding”, “approachable” and “good leader” (Byrom & Downe, 2010:133). Nicholls and Webb (2006:425) describe caring characteristics as being “pleasant” and “friendly”. Terms used in relation to significant personality traits of a “good midwife” as reported by Feijen-de Jong et al. (2017:157, 159-161) were “unique”, “spontaneous”, “having life experience”, “working hard”, “independent” and “smart”. Borrelli (2014:3-5, 7, 9) mentions the importance of specific personal qualities needed in a “good midwife” but does not expand on what these are considered to be.

Affective component and attitude are mentioned synonymously in the midwifery literature (Byrom & Downe, 2010:126, 130; Nicholls & Webb, 2006:414, 422). A caring attitude is specifically noted as an important requirement of a “good midwife” (Byrom & Downe, 2010:135; Feijen-de Jong et al., 2017:159; Nicholls & Webb, 2006:424-425). Support emerged as an essential requirement in the affective component of a “good midwife” (Nicholls & Webb, 2006:414, 422; Feijen-de Jong et al., 2017:159), displayed in the midwife’s capacity to give the labouring woman choice, continuity and control (Nicholls & Webb, 2006:422,424,427). A supportive relationship is built through communication skills that ultimately empower the labouring woman and ensures that the relationship is built on trust (Byrom & Downe, 2010:129; Feijen-de Jong et al., 2017:159-160; Nicholls & Webb, 2006:424). To be truly effective, the relationship should be established quickly (Byrom & Downe, 2010:127), confirming the importance of strong communication skills. A positive attitude is also considered to be vital (Feijen-de Jong et al., 2017:160; Nicholls & Webb, 2006:422). The general attitude sought after in a “good midwife” was described in terms such as “warmth”, “fairness”, “empathy”, “kindness” and “friendly” (Byrom & Downe, 2010:135).

“Good midwives” make their patients feel safe because they are always “present” (Feijen-de Jong et al., 2017:158; Masala-Chokwe & Ramukumba, 2015:6; Ménage et al., 2017:558; Nicholls & Webb, 2006:427). This involves both physical and emotional
presence, regarded as demonstrating compassion in action (Feijen-de Jong et al., 2017:160).

To create better birthing experiences, kindness and compassion are needed, yet little is known about what midwives perceive this in midwifery practice.

2.10 Conclusion

Chapter two began with an introductory reminder of the issues discussed in Chapter one. Details were then given of the search strategy. Key distinctions were explained between sympathy, empathy and compassion; explanation was given of kindness and compassion; the characteristics of compassion were outlined; the process of compassion was discussed; research on compassion in nursing fields were identified, including specific focus on elderly care, medical-surgical care and emergency care; and a discussion was presented of compassion in midwifery, ending with an explanation of the “good midwife” concept. This concludes Chapter two, the literature review.
CHAPTER 3:
ARTICLE MANUSCRIPT

3.1 Chapter three outline

This chapter was written according to the article format as stated in the NWU Manual for Master's and Doctoral studies concerning submitting a dissertation. One manuscript was written following the instructions for authors as per the BMC Pregnancy and Childbirth Journal, hence repetition – in some instances verbatim of what was written in Chapter one and Chapter two. The references were recorded according to the reference style as indicated in the instructions for authors for the BMC Pregnancy and Childbirth Journal.

The chapter outline is as follows:

Section I: Article instructions for authors

Section II: Cover letter to the Editor-in-Chief of the BMC Pregnancy and Childbirth Journal

Section III: Article manuscript for submission to the BMC Pregnancy and Childbirth Journal

3.2 Section I

Instructions for authors according to the BMC Pregnancy and Childbirth Journal to follow:

Instructions for authors

Research articles

Criteria | Submission process | Preparing main manuscript text | Preparing illustrations and figures | Preparing tables | Preparing additional files | Style and language

Assistance with the process of manuscript preparation and submission is available from BioMed Central customer support team. See 'About this journal' for information about policies and the refereeing process. We also provide a collection of links to useful tools and resources for scientific authors on our page.

Criteria

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Submission process

Manuscripts must be submitted by one of the authors of the manuscript, and should not be submitted by anyone on their behalf. The corresponding author takes responsibility for the article during submission and peer review.

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See below for examples of word processor and graphics file formats that can be accepted for the main manuscript document by the online submission system. Additional files of any type, such as movies, animations, or original data files, can also be submitted as part of the manuscript.

During submission you will be asked to provide a cover letter. Use this to explain why your manuscript should be published in the journal, to elaborate on any issues relating to our editorial policies in the ‘About *BMC Pregnancy and Childbirth*’ page, and to declare any potential competing interests.

Assistance with the process of manuscript preparation and submission is available from BioMed Central customer support team.

We also provide a collection of links to useful tools and resources for scientific authors on our Useful Tools page.

File formats

The following word processor file formats are acceptable for the main manuscript document:

- Microsoft word (DOC, DOCX)
- Rich text format (RTF)
- Portable document format (PDF)
- TeX/LaTeX (use BioMed Central's TeX template)
- DeVice Independent format (DVI)

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If you have used another template for your manuscript, or if you do not wish to use BibTeX, then please submit your manuscript as a DVI file. We do not recommend converting to RTF.

For all TeX submissions, all relevant editable source must be submitted during the submission process. Failing to submit these source files will cause unnecessary delays in the publication procedures.

Publishing Datasets

Through a special arrangement with LabArchives, LLC, authors submitting manuscripts to BMC Pregnancy and Childbirth can obtain a complimentary subscription to LabArchives with an allotment of 100MB of storage. LabArchives is an Electronic Laboratory Notebook which will enable scientists to share and publish data files in situ; you can then link your paper to these data. Data files linked to published articles are assigned digital object identifiers (DOIs) and will remain available in perpetuity. Use of LabArchives or similar data publishing services does not replace preexisting data deposition requirements, such as for nucleic acid sequences, protein sequences and atomic coordinates.
Instructions on assigning DOIs to datasets, so they can be permanently linked to publications, can be found on the LabArchives website. Use of LabArchives’ software has no influence on the editorial decision to accept or reject a manuscript.

Authors linking datasets to their publications should include an Availability of supporting data section in their manuscript and cite the dataset in their reference list.

**Preparing main manuscript text**

General guidelines of the journal's style and language are given below.

**Overview of manuscript sections for Research articles**

Manuscripts for Research articles submitted to *BMC Pregnancy and Childbirth* should be divided into the following sections (in this order):

- Title page
- Abstract
- Keywords
- Background
- Methods
- Results and discussion
- Conclusions
- List of abbreviations used (if any)
- Competing interests
- Authors’ contributions
- Authors’ information
- Acknowledgements
- Endnotes
- References
- Illustrations and figures (if any)
- Tables and captions
- Preparing additional files

The Accession Numbers of any nucleic acid sequences, protein sequences or atomic coordinates cited in the manuscript should be provided, in square brackets and include the corresponding database name; for example, [EMBL:AB026295, EMBL:AC137000, DDBJ:AE000812, GenBank:U49845, PDB:1BFM, Swiss-Prot:Q96KQ7, PIR:S66116].

The databases for which we can provide direct links are: EMBL Nucleotide Sequence Database (EMBL), DNA Data Bank of Japan (DDBJ), GenBank at the NCBI (GenBank), Protein Data Bank (PDB), Protein Information Resource (PIR) and the Swiss-Prot Protein Database (Swiss-Prot).

For reporting standards please see the information in the About section.

**Title page**

The title page should:

- provide the title of the article
- list the full names, institutional addresses and email addresses for all authors
- indicate the corresponding author

Please note:

- the title should include the study design, for example "A versus B in the treatment of C: a randomized controlled trial X is a risk factor for Y: a case control study"
- abbreviations within the title should be avoided
- if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the
“acknowledgements” section in accordance with the instructions below. Please note that the individual names may not be included in the PubMed record at the time a published article is initially included in PubMed as it takes PubMed additional time to code this information.

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The Abstract of the manuscript should not exceed 350 words and must be structured into separate sections: Background, the context and purpose of the study; Methods, how the study was performed and statistical tests used; Results, the main findings; Conclusions, brief summary and potential implications. Please minimize the use of abbreviations and do not cite references in the abstract. Trial registration, if your research article reports the results of a controlled health care intervention, please list your trial registry, along with the unique identifying number (e.g. Trial registration: Current Controlled Trials ISRCTN73824458). Please note that there should be no space between the letters and numbers of your trial registration number. We recommend manuscripts that report randomized controlled trials follow the CONSORT extension for abstracts.

Keywords

Three to ten keywords representing the main content of the article.

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The Background section should be written in a way that is accessible to researchers without specialist knowledge in that area and must clearly state - and, if helpful, illustrate - the background to the research and its aims. Reports of clinical research should, where appropriate, include a summary of a search of the literature to indicate why this study was necessary and what it aimed to contribute to the field. The section should end with a brief statement of what is being reported in the article.

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The Results and discussion may be combined into a single section or presented separately. Results of statistical analysis should include, where appropriate, relative and absolute risks or risk reductions, and confidence intervals. The Results and discussion sections may also be broken into subsections with short, informative headings.

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This should state clearly the main conclusions of the research and give a clear explanation of their importance and relevance. Summary illustrations may be included.

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We suggest the following kind of format (please use initials to refer to each author's contribution): AB carried out the molecular genetic studies, participated in the sequence alignment and drafted the manuscript. JY carried out the immunoassays. MT participated in the sequence alignment. ES participated in the design of the study and performed the statistical analysis. FG conceived of the study, and participated in its design and coordination and helped to draft the manuscript. All authors read and approved the final manuscript.

All contributors who do not meet the criteria for authorship should be listed in an acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, a department chair who provided only general support, or those who contributed as part of a large collaboration group.

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Acknowledgements

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The role of a scientific (medical) writer must be included in the acknowledgements section, including their source(s) of funding. We suggest wording such as 'We thank Jane Doe who provided medical writing services on behalf of XYZ Pharmaceuticals Ltd.'

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*Article within a journal by DOI*

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*Online document*

*Online database*
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- Description of data

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Ideally, file formats for additional files should not be platform-specific, and should be viewable using free or widely available tools. The following are examples of suitable formats.

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  - PDF (Adobe Acrobat)
- Animations
  - SWF (Shockwave Flash)
- Movies
  - MP4 (MPEG 4)
  - MOV (Quicktime)
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1. Create a folder containing a starting file called index.html (or index.htm) in the root.
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3. Ensure that all links are relative (ie "images/picture.jpg" rather than "/images/picture.jpg" or "http://yourdomain.net/images/picture.jpg" or "C:\Documents and Settings\username\My Documents\mini-website\images\picture.jpg") and no link is longer than 255 characters.
4. Access the index.html file and browse around the mini-website, to ensure that the most commonly used browsers (Internet Explorer and Firefox) are able to view all parts of the mini-website without problems, it is ideal to check this on a different machine.
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*BMC Pregnancy and Childbirth* will not edit submitted manuscripts for style or language; reviewers may advise rejection of a manuscript if it is compromised by grammatical errors. Authors are advised to write clearly and simply, and to have their article checked by colleagues before submission. In-house copyediting will be minimal. Non-native speakers of English may choose to make use of a copyediting service.

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**Abbreviations**

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- Use hard returns only to end headings and paragraphs, not to rearrange lines.
- Capitalize only the first word, and proper nouns, in the title.
- All lines and pages should be numbered. Authors are asked to ensure that line numbering is included in the main text file of their manuscript at the time of submission to facilitate peer-review. Once a manuscript has been accepted, line numbering should be removed from the manuscript before publication. For authors submitting their manuscript in Microsoft Word please do not insert page breaks in your manuscript to ensure page numbering is consistent between your text file and the PDF generated from your submission and used in the review process.
- Use the [BMC Pregnancy and Childbirth reference format](http://old.biomedcentral.com/bmcpregnancychildbirth/authors/instructions/researcharticle).
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- Please do not format the text in multiple columns.
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SI units should be used throughout (liter and molar are permitted, however).

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3.3 Section II

Cover letter to the Editor-in-Chief of the BMC Pregnancy and Childbirth Journal:

Editor-in-Chief

BMC Pregnancy and Childbirth Journal

RE: ARTICLE FOR SUBMISSION

The article titled: “The characteristics of kind and compassionate care during childbirth according to midwives: a qualitative descriptive inquiry” is hereby submitted.

The article was not submitted to any other journal. Please note, that the article was approved for submission by contributing authors. Ethical approval was obtained from the North-West University (NWU) (Certificate number: NWU-00072-16-A1) in order to conduct the empirical study. The study was funded by the principle investigator through the PLUME researcher development program of the Forum of University Nursing Deans of South Africa (FUNDISA) and the National Research Foundation (NRF) after peer review. The researcher declares a NWU post-graduate bursary for part-time students as well as staff discount, as the researcher is employed on a fixed term contract for the School of Nursing Science as a Clinical Preceptor. No conflict of interest is declared.

Thank you for considering this manuscript for publication.

Kind regards,

S.S. Krausé
3.4 Section III

Article manuscript as prepared for submission

The characteristics of kind and compassionate care during childbirth according to midwives: a qualitative descriptive inquiry.

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Abstract

Background

Although compassion is considered to be of prime importance in nursing and midwifery care, there is no clear understanding of what compassionate care in childbirth entails, and how midwives’ perceive compassionate care is largely unknown. This study accordingly seeks to explore and describe the characteristics, as perceived by midwives, of kind and compassionate care during childbirth.

Methods

A qualitative descriptive inquiry was undertaken by means of a voluntary online survey, where participants were recruited via snowball sampling on the social networking site Facebook. The participants were midwives, and the unit of analysis was the received response. Participants gave written responses reporting on instances of kind and compassionate care during childbirth. The data was thematically analysed using Tesch’s eight steps to identify common themes.

Results

Ninety-eight responses from participants were analysed and three themes and 11 sub-themes emerged as dominant characteristics. Themes and sub-themes were as follows: making meaningful connections with patients (displaying good interpersonal skills, conduct based on dignity and respect, establishing trust); initiating individualised understanding of each patient (showing empathy, being patient, permitting maternal choice, promotion of advocacy, non-judgemental attitude) and action through care and support (providing emotional support, assistance through instrumental support, continuous informational support).

Conclusion

The characteristics of kind and compassionate care were identified as follows: (i) making meaningful connections with patients by displaying good interpersonal skills and showing dignity and respect, and establishing trust; (ii) initiating individualised understanding of each patient the midwife comes into contact with by showing empathy, being patient, permitting maternal choice, promotion of advocacy and having a non-judgmental attitude; and (iii) acting to provide care and support in the form of emotional support, instrumental support assistance, and continuous informational support. In seeking to determine what
characterises compassionate care, a pivotal consideration is relationship based on trust involving a distinctive understanding of the individual patient and her individual needs. Unique to this study was the finding that participants regarded advocacy as a characteristic of compassionate midwifery care. There was also an emphasis on not judging the labouring woman, as it hindered the connected relationship created. By acting on the information gathered through connections and shared understandings the midwife provides compassionate emotional, instrumental and informational care and support. Better understanding of how midwives perceive compassionate care could potentially improve the quality of care midwives offer during childbirth.

**Keywords**

Attributes, kindness, compassion, labour, birth, midwifery, perception, understanding, thematic analysis
Introduction

Midwives work together with women during their pregnancy, labour and puerperium stages and global standards have been set for the minimum cognitive and psychomotor competencies required of a midwife [1]. In the midwifery literature, a recent shift has increased attention to affective competencies with particular focus on the notion of the “good midwife”. Competency in the affective domain has been described as the use of emotions and feelings such as compassion, kindness, empathy and support [2-4] of which compassion is considered of prime importance [5] and pivotal to quality nursing and midwifery care [6-7]. Although researchers are exploring the term compassion in nursing [5-6], little is known about what constitutes compassionate care in midwifery [7], which according to the authors is essential to improve midwifery care [2, 4, 7] and decrease the incidence of disrespect and abuse [8].

Background

Midwives are often the main caregivers for healthy women during childbirth [9-11] and have been referred to as the “backbone” of maternal and newborn care [9]. Globally, the ICM guides midwifery associations and their governments on the minimum cognitive and psychomotor competencies required of a midwife [1-2, 4, 11]. Once deemed competent, the midwife may practice in whichever context is applicable: the home; the community; hospitals; clinics or health units [1]. The competent midwife then works together with women, taking full responsibility and liability for their pregnancy, labour and puerperium care [11].

How the midwife cares for the woman during childbirth is associated with deep personal and cultural significance for the woman herself and for her family [12]. Hence the focus, as noted above, on the affective domain in midwifery, in addition to cognitive and psychomotor competencies [2]. A “good midwife” so termed, is one who is competent in the cognitive, psychomotor and affective domains [2, 4, 13]. Competency in the affective domain has been described as use of soft skills, such as compassion, kindness, empathy and support [2-4]. Compassion is considered to be so important in the affective competencies of a registered midwife that suggestions have been made to add it as a core competency in midwifery care [14-16].
Recently, there have been an alarming number of reports of disrespect and abuse during childbirth [8, 12, 17-21]. This has been noted by the World Health Organization (WHO) as a serious problem that needs urgent attention [22]. Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful care [23]. A recent WHO advisory on positive childbirth experience makes recommendations on how to manage and minimise disrespect and abuse by providing compassionate care to all women [24].

Compassion is defined in the literature as feeling together [25], feeling with another [26], and subsequently taking action or performing deeds of kindness [27] to provide relief for suffering or pain [7, 26, 28]. In this study, deeds of kindness are understood as action taken beyond the normal or routine ambit of the midwife’s care: supererogatory deeds – expressed in metaphorical terms as “going the extra mile” or “going above and beyond” [29]. Compassion and kindness are accordingly regarded in this study as a single concept, and mention of compassion includes the assumption of kindness.

Compassion has been cited as possibly the most highly valued attribute in nursing and midwifery care [6, 26, 30] and is widely recognised as its core element [25-26, 31-34]. Compassion is described as a constituent of nursing excellence [30] and as a vital component for achieving quality nursing and midwifery care [5, 15, 35-38].

Compassion is thus undeniably sought for in nursing and midwifery care [30, 32]. Yet how compassion manifests itself in provision of care is poorly understood, as it differs from practitioner to practitioner and from practice setting to practice setting [5, 26, 33, 37, 39]. Ménage et al. [7] note that there is no clear understanding of what compassionate care in childbirth entails and midwives’ perceptions of compassionate care is largely unknown. This study was accordingly undertaken to explore and describe midwives’ perceptions of kindness and compassion in caregiving for women in childbirth.

**Methods**

In this study, a qualitative descriptive research design was chosen in response to deficit in the understanding of the concept of compassionate care in midwifery [40]. A descriptive design is suitable when describing accounts from practice to develop a meaningful understanding of an ill-explored concept [41].
Data were collected through a voluntary, anonymous online survey. Electronic surveys have been reported as equivalent to paper-based surveys in terms of internal reliability and completion rates [42-43]. The benefits of online surveys are that they save time, are cost-effective, and can be accessed quickly by people with shared characteristics from widely separated geographical locations [44-45].

A Facebook page was created entitled “Promoting kind and compassionate care during childbirth.” The target population was recruited using a snowball sampling technique via midwife-based groups and pages on Facebook using the search words “midwife” and “childbirth”. Typically, each Facebook user has their own network of friends, family and Facebook groups (i.e., virtual communities linking people with common interests). Interested midwives were invited to like and share the study’s Facebook page (with the link to the online survey); this increased the likelihood of other midwives taking cognizance of the study, thereby propelling the snowball sampling process.

Facebook was chosen as the social networking site (SNS) for recruiting participants as it is reportedly the largest online community [46]. SNS’s offer new ways for researchers to conduct studies quickly and cost-effectively, particularly in constructing snowball samples for descriptive work [46-48].

The Facebook page contained a link to the SurveyMonkey electronic platform used for the self-administered survey. SurveyMonkey was chosen as the online site to collect and store data in view of favourable features it offers such as affordability, easy format and possibility to set up surveys as desired [49]. An invitation to participate in the proposed study was posted on the Facebook page.

**Population and sample**

The target population was midwives practicing in South Africa and elsewhere. The units of analysis were the responses from each midwife, not the midwives themselves. Inclusion criteria for midwives were experience in assisting women during childbirth and having internet access (more specifically a Facebook account following a midwife-orientated group). As the aim of the study was to gain understanding about kind and compassionate care in midwifery, no limit was placed on the number of responses received. If there was more than one incident midwives wished to report, they were invited
to do so, since any incident profound enough to make an impact on the midwife was deemed relevant. For this same reason, there were no exclusion criteria.

The researcher could not predict a specific sample size due to the descriptive nature of the research problem and the unpredictability of the number of replies. Hill [50] indicates a wide range of possibilities (from 30 to 500) for recommended sample size in an online survey, with a small sample size being more economical while a larger sample adds reliability and representativeness [50]. This study fell somewhere in the lower end of the sample size, with 98 completed responses received. This was considered to be sufficient as data saturation took place. Data saturation occurred once similar themes repetitively stood out.

The survey was open for three months for data collection from the 13th of December 2016 to the 13th of March 2017. In an online survey reported by Bhutta [46], the majority of the responses were received within the first few days following the survey launch [46]. However, in this study less than 50 responses were received within the first month. A second invitation was therefore posted on the Facebook page, and a further 48 responses were then received over the subsequent two months.

**Data analysis**

Thematic analysis was carried out according to Tesch’s eight steps as explained by Creswell [40]. Thematic analysis was the most appropriate means to analyse this data set, as the objective of the study was to explore and describe the characteristics of a specific concept [40]. Braun and Clarke [51] explain that thematic analysis is “a method of identifying, analysing and reporting patterns within data.” Patterns can also be referred to as themes [51]. This makes it possible to identify a common train of thought in the responses received from the participants [52].

The data analysis took place as follows: the data was transferred to an Excel spreadsheet, thereafter imported into the qualitative research program Atlas.ti 8, which was used to process the large amount of data into a smaller set of easily readable interpreted themes [53]. The data were managed and arranged by numbers according to the sequence in which responses were received. As this was an anonymous survey, no other identifying criteria were available.
Tesch’s eight steps as explained by Creswell [40] were carried out as follows in the thematic analysis: the data set was read over to obtain a general idea of what was said. Next, it was looked at in greater detail to begin the coding process. Coding is defined by Creswell [40] as the process of taking a large amount of data and breaking up into smaller sections before attaching meaning to it. These smaller sections were named following the to open coding process of giving labels or renaming sections of the data set to find and categorise shared meanings. The data set was read through several times to get an idea of what the participants had to say. The most interesting responses from participants were identified and explored to determine their fundamental meaning. A list of topics surfaced that had been brought up several times by different participants. New categories originated from reading through the responses from the participants again. These were then refined and grouped according to similar meanings, resulting in a list of final categories – labelled as themes– which had come to light [40].

**Ethical considerations**

The link to SurveyMonkey took potential participants to an introduction page which was simultaneously utilized as electronic informed consent. On this page the participants were formally invited to participate in the research project, with a statement declaring the research question and aim, and the inclusion criteria for the voluntary study were specified. The open-ended questions were stated so as to prepare the participants for the expectations of the low-risk study so that they understood it would not have any direct benefit for participants. Participants were encouraged to contact the researcher should there be any level of psychological distress experienced for assistance or referral. Password protection of data gave participants assurance of the confidentiality and anonymity of the study. Participants were asked to confirm that they were 18 years or older; understood the information stated and wanted to complete the survey by clicking on the accept button.

Anonymity was ensured as no names or contact details were requested. The completed surveys were identified in the sequence that the participants submitted. Anonymity and confidentiality was thus not compromised.
Ethical approval was granted by the Health Research Ethics Committee (HREC) of North-West University [certificate number: NWU-00072-16-A1]. As the study took place online, no further legal authorization or goodwill consent was necessary.

**Trustworthiness**

The four fundamental epistemological standards listed by Lincoln and Guba [54] were applied to ensure the trustworthiness of this qualitative study. Theoretical validity was provided by conceptualisation of the central concepts described in the study [55].

Prolonged engagement in the field of midwifery and in the collection and analysis of data, and peer debriefing with the principle investigator and co-supervisor, enhanced the credibility of the study findings. Transferability was strengthened by providing a thorough account of the research process applied in the study and by analysing all data entries even after data saturation was reached. The dependability of the study was enhanced through review, approval and monitoring from the applicable scientific committees and study leaders associated with this study. A co-coder was assigned to thematically analyse the data set. The codes were subsequently worked on individually. The researcher and the co-coder obtained inter-coder agreement regarding the open codes [40]. The researcher declares a non-biased approach to the study, increasing the confirmability of the results.

**Findings**

The self-administered survey consisted of a demographic section with five closed-ended questions and three open-ended questions. According to Callegaro et al. [44], an advantage of open-ended questions is that participants have an opportunity to re-tell a life event that made an impact on them in as much detail as needed, thereby revealing how the concept is perceived (in this case, by the midwife). Closed-ended questions, on the other hand, do not provide much insight. The disadvantage of open-ended questions is that it might be a cognitive strain to answer them; they were accordingly kept to a minimum in this study [44]. The survey was not time-consuming, as the expected completion time was 15 to 30 minutes.

The closed-ended questions (with the options for choice of one standard answer indicated in brackets) were as follows:
What is your gender? (male or female)
Where do you practice midwifery? (rural area or urban area)
In which facility do you practice midwifery? (state hospital, private hospital, community health centre, private practice that is midwife-lead or other)
How many years’ experience do you have working as a midwife? (1-5 years, 6-10 years, 11-20 years, 21-30 years or 30 plus years)
Is this the first time you are answering the survey? (yes or no).

Concise instructions were given, followed by the three open-ended questions. Two were explicitly phrased:

- Please write a paragraph about an instance in which you saw or experienced kind and compassionate care during childbirth.
- List five words that you associate with kind and compassionate maternity care.

The third made provision for participants to contribute any additional comments. Once the survey was complete, the participant was asked to click on the “submit” button.

There were 98 completed responses to the online survey, of which 10 participants repeated the survey. A response was considered to be completed when all 10 of the questions were answered without any questions having been skipped. Only female midwives responded to the online invitation. The majority of participants indicated practicing in urban midwife-led facilities and had on average 1 to 5 years of midwifery experience. See Table 1 for the collected demographic data of the participants.

PREFERRED PLACEMENT OF TABLE 1

Table 2 sets out the reported instances of kind and compassionate care during childbirth in relation to three main themes and 11 subthemes.

PREFERRED PLACEMENT OF TABLE 2

**Theme 1: MAKING MEANINGFUL CONNECTIONS WITH PATIENTS**

Participants felt that the midwife typically connects with the mother in labour by becoming in tune with her and creating a bond. This connection flows when the midwife and the labouring mother actively collaborate with one another through interpersonal skills, dignity and respect, and establishing trust.
Displaying good interpersonal skills

*Interpersonal skills* is a broad term indicating capacity to communicate with others through combined verbal and non-verbal communication and active listening. Participants emphasised the importance of using positive, affirming language when communicating with their patients and speaking softly and calmly. Examples were given of basic communication skills such as introducing yourself and more complex skills such as connecting with a patient in tragic situations. The importance was also highlighted of listening and using non-verbal cues such as facial expression, tone of voice and touch.

Participants made explicit reference to listening and the importance of being a good listener for good communication.

Participant 93:

*When the client is listened to, when her feelings are taken note of...*

Non-verbal communication was frequently mentioned, with references to smiles, eye contact and touch.

Participant 73:

*... A glance a look from a woman can be interpreted by a midwife and reassurance given from a look.*

**Conduct based on dignity and respect**

Participants discussed experiences where the midwife overtly displayed respect and maintained an overall framework of respect, particularly respect for bodily autonomy. This reinforced the connection between the midwife and the labouring woman, and was described as an essential part of compassionate care.

Participant 39:

*... Simple gestures of covering her body to respect her dignity; acknowledging and respecting her wishes...*
Participant 47:

… I attended a home birth… She is a modest woman so we kept her lap covered with a towel during the birth which helped her feel more comfortable. We also did not perform any vaginal examinations for this particular client and instead we watched her contraction pattern and trusted her with what she was feeling. The birth was perfect and healthy, and all appropriate customs were performed with minimal interference and with great respect from the midwives…

Establishing trust

In relation to the subtheme establishing trust, two features stood out: establishing partnership between the midwife and the labouring mother, and creating a strong sense of safety. Trust should be established quickly, with many participants using terms such as honesty, integrity and maintaining privacy and confidentiality to describe how the meaningful connection is strengthened.

Participant 64:

Caring for a hardened criminal who did not want to engage, by being kind, gentle, inclusive and treating the couple as equals, trust was created and they engaged. They were very thankful and said they have never been treated so kindly by health professionals.

Participants mentioned strong focus on relationships between the midwife and mother in labour. There was an emphasis on relational building and on being partners or teammates during delivery, with partnerships being non-authoritarian.

Participant 76:

… It is hard to put into words as it is intangible and it does not differ from being ‘kind’. Many practitioners are ‘kind’ but compassionate care is fuller and involves more equality in the relationship.

Participants referred to feeling a sense of safety and trust when kind and compassionate care was practised.
Participant 83:

In a homebirth situation, where the couple had got to know their midwife through the antenatal period and were therefore able to be in a place of safety, feeling trust in their carer.

Theme 2: INITIATING INDIVIDUALISED UNDERSTANDING OF EVERY PATIENT

Participants described compassionate care as personal, referring to the women they are caring for in labour as "my women". Compassion in caring for labouring woman made it seem as if the midwife was caring for her own family. Participants often made the point that each labouring woman is unique and should be seen as an individual, not just someone you had a duty to give compassionate care to; everyone has their own individual needs and wishes. Participants recounted numerous instances where the essence of compassion was shown in the midwife’s empathy, in being patient at all times, respecting maternal choice, and, in extreme circumstances, speaking on behalf of the labouring woman when she was not able to speak for herself.

Showing empathy

Participants recounted numerous incidents where the midwife showed how much she cared through expressions and gestures such as crying with the labouring women in moments of great sorrow and pain.

Participant 15:

I was working in a busy labour and delivery unit. One afternoon, (it was extremely busy that day and at the end of the shift: we were all so tired), I heard the most horrific scream from the room (unlike what we heard from our patients in this particular unit), I went in and saw the Gynaecologist examine and hurt the patient. With the patient was a midwife I had the world’s respect for! She was holding the patient and crying with her, as if she herself felt this excruciating pain…

Participant 29:

When the midwife left the room, I went and sat next to the mom and held her hand. I understood something that day that I’m carrying with me
today still… for you it may seem like just another patient having a baby. But for this mother it was her first baby. After holding her hand and wiping her face for a while, the mom appeared calmer…

**Patience**

Patience came through as an intrinsic element of kind and compassionate care during childbirth. Patience meant being unhurried and not setting time limits. Words such as *warmth, gentle* and *love* were used in accounts indicating patience shown by midwives.

Participant 26:

*A birth I witnessed at our private birthing facility in which the midwife conducting the birth was patient with the mom. It took long to push baby out. She never got frustrated or upset, or used abusive language.*

Participant 66:

*…But the midwife present at that delivery, stood by her and comforted her for the whole 8 hours, even though the patient was not pleasant. She handled the patient with so much love. After the delivery that women was so grateful and named her baby after the midwife.*

Examples of not being rushed and not setting time limits came out in accounts of midwives taking extra time and allowing the mother all the time she needed.

Participant 49:

*Every time someone takes the time to know the woman, know her history, understand her concerns, her fears and her desires and then creates a plan; whatever that may be….*

**Prioritising maternal choice**

In relation to the *choice* sub-theme participants discussed the importance of the labouring woman being able to make an informed choice between alternative options. They stressed that maternal choice should be given priority and that the mother should have the biggest say in the management of the delivery.
Participant 81:

… The midwife made it clear my client had choices, that they were going to be led by her...

Participant 92:

On a regular basis just providing choices to women and families and offering personalized care that is tailored to each unique birth and life circumstance.

Promotion of advocacy

Participants felt that everyone deserves kind and compassionate care during childbirth. In instances where this was not the case, participants described experiences where the midwife was an advocate for the patient and spoke on behalf of the patient when this was called for.

Participant 15:

The midwife very calmly and professionally told the Doctor that she did not approve of her behaviour. This will stay with me forever. ——* is such a frail, tiny, humble human being with the biggest heart: exceptional compassion for her fellow human beings and patients and the lion’s-courage to stand up against bullies. She is my hero.

* Name omitted to preserve anonymity

Participant 50:

A midwife standing up for a woman’s birth plan in a way which shielded the woman from the negative bullying process.

Non-judgemental attitude

Participants spoke of situations where the midwife refused to make negative judgements about the patient, but instead focused on being objective and understanding.
Participant 79:

...she had the most amazing experience because the midwife trusted in her and stood by her side without judgement...

Participant 88:

The biggest challenge I ever had was providing care to a 9 month pregnant prostitute who admitted to drinking half a gallon of vodka a day. The whole of the nursing staff were so angry at this patient. But she was labouring and in pain, and it took everything to stay kind.

**Theme 3: ACTION THROUGH CARE AND SUPPORT**

Participants explained how compassion can be shown through emotional, instrumental and informational care and support. In emphasising the importance of giving support and encouragement there were some accounts that referred to allowing the woman to follow her instincts and lead her own birth uninterrupted, providing only what is needed and wanted. Supervision and encouragement were seen as emotional support; physical interventions to provide relief were seen as instrumental support and instruction and advice were seen as informational support.

**Providing emotional support**

Participants recounted numerous experiences where the midwife used encouraging words to support the patient emotionally. They also described instances where it was the midwife’s presence that gave emotional support to the patient, such as the midwife going beyond the call of duty by staying on after the end of her shift to continue that support.

Participant 17:

...in the end the midwife stayed with the patient until she delivered, even after the midwife was done with her shift.

Participants also referred to instances where midwives offered calm reassurance to assist and comfort labouring women.
Participant 91:

When the midwife reassuring the mother to hold on through labour stages, managing pain and giving her support, and reminding the mother that it will be worth it when she holds her baby in her hands.

Participants stated that they felt empowered by the midwife’s care and support, as in the following participant’s comments.

Participant 32:

Kind and compassionate care happens when a midwife and team comes around a woman and empower her to have the best birthing experience she can ever have. I see it all the time as I am doing woman centred care, allowing women to be in charge of their birth…. I see it when women can move freely during their labour and birth, never have to be by themselves and are coached and encouraged right through. Where there is no room for fear and anxiety.

Assistance through instrumental support

Participants spoke of action-oriented support and care shown by midwives in assistance to relieve discomfort or pain, such as administration of analgesia or physical intervention such as a massage, judged according to the patient’s need.

Participant 27:

Wiping the brow between contractions and gently whispering how strong she is.

Instances were also mentioned where tangible aid was given as an act of kindness and compassion.

Participant 51:

Providing the birthing woman with eggs after she had given birth and she had no food in the house.
Participant 96:

*I was delivering someone’s baby and that mother didn’t have any clothes for the baby so as midwives we donated money and clothing for the baby.*

**Continuous informational support**

Participants related stories of midwives providing care and support to the labouring woman by giving her information in the form of advice, useful instructions, helpful suggestions and guidance. There was also emphasis on the importance of giving positive feedback.

Participant 81:

*She was greeted warmly by our allocated midwife and having checked the fetal heart rate remained normal, took time to explain what was going to happen next, and gave her opportunity to ask questions.*

Participant 21:

*A midwife was explaining the death of the parent’s unborn child to them with so much love and compassion that they were feeling a lot more peaceful about letting their child go. An awesome experience I will remember for the rest of my life.*

**Discussion**

This study sought to identify what midwives regarded as characterising kind and compassionate care during childbirth. What the participants described were experiences of kind and compassionate care displayed through creation of a meaningful connection with the patient, followed by individualized understanding of each patient and leading to appropriate action taken in the giving of care and support. This is similar to the process of compassion outlined by Ménage et al. [7] in their concept analysis [7]. Broadly, the process of compassion has been described as originating in recognition of discomfort in others, accompanied by a desire to ease it [7, 16, 26, 32] which is subsequently manifested in meeting the identified need.

The participants’ descriptions of the connection created resemble what has been reported in literature [16, 39] and was seen as crucial for provision of compassionate care. When
compassionate care is practiced, an authentic bond is created between the practitioner and the patient, described by Byrom and Downe [2] as “this unseen thing”. Establishing connectedness in the practitioner–patient relationship is a highly affective process [7] in which the practitioner intentionally becomes accustomed to the patient [5, 29, 56], resulting in a close and meaningful relationship [57]. Compassionate practice enables therapeutic relationships to be created through interpersonal skills [37], particularly through verbal communication such as introducing oneself [57], through non-verbal communication such as eye contact, smiling and touch [37] and through being a good listener [34, 58]. Respect has been highlighted as an important characteristic of compassion [3] and of being considerate and willing to compromise [39]. Cummings and Bennett [15] also found that a relationship based on dignity and respect results in compassionate care, seen as the foundational principle in how to care for others.

In relation to midwives establishing meaningful connections, issues that participants raised included being attentive to the patient [59], focusing on the individualized understanding of the patient [16, 59] and adopting a collaborative approach [39]. This enables the midwife to be involved with, and recognize what especially matters for each individual patient [5, 29]. It has been stressed that understanding is created by looking at each patient in their current situation [57] and generating unique applications according to each particular set of circumstances [60].

When midwives have the ability to treat women as individuals [4], compassionate care can flow. Participants felt that there should be a stronger emphasis on an individualized approach to care, since women want to be understood by the practitioner caring for them [61]. Participants felt that an important aspect of compassion is seeing your patient (in the words of one participant) as an “individual and not a duty”, which is supported by authors who highlight the importance of humanizing the patient [35, 57].

The issue of empathy came up frequently in participants’ descriptions of compassion, and is supported in the literature [2-4, 7, 10, 61]. One study linked compassion with trustworthiness and patience [34], and this also came through as important characteristics of compassion in this study. Davison et al. [62] noted that labouring woman prefer midwives who give individualized attention and accommodate the particular needs of each childbearing woman; reference is also made by the authors to reaching a shared
goal [62]. Berg et al. [63] stress the importance of supporting and guiding the labouring woman according to her own terms so that she has a sense of control.

Linkage between advocacy and compassion does not appear to have been discussed in the literature and is thus considered to be a unique finding in this study. Crawford et al. [64] use the term *non-judgmental* to describe a characteristic of a “compassionate mentality”.

however, applying this term as a characteristic of kind and compassionate care during childbirth appears to be a further unique finding.

Once the midwife has connected with and understood the patient, she can act in a way that matters to the labouring woman and execute the care [58]. Compassion is frequently defined as an action-oriented state [5, 29] in which activities are carried out [28, 7, 60] and the deeds-based character of compassion [36] is shown by small acts of kindness [5, 29, 57] carried out in an attempt to alleviate discomfort [32, 38, 56]. This corresponds with descriptions participants gave of emotional, instrumental and informational care and support. Compassion shown through presence of the midwife, as described by participants, is also reported in the literature [3-4, 7, 10, 59].

Characteristics of compassion found in long-term care were attentiveness, involvement and helping, and were found to be motivational in achieving agreed-upon goals [59], also emerged in the theme *action through care and support*. Midwives determination to support and encourage women reflects the affective nature of compassion [7].

**Limitations of the study**

Paucity of descriptions of compassion in midwifery care appeared to be a limitation in the early stages of the study but as the study progressed this became a strength, since there is a definite gap in the literature regarding midwives’ perception of compassion. This empirical study is thus able to contribute to the body of knowledge, as it identified unique findings as well as providing a starting point for continued future investigations into the concept.

A limitation of the study was that only midwives with an active Facebook account were eligible for inclusion in the study. The sample may not be exactly representative, as it is not required of midwives that they have access to the internet or Facebook accounts [44].
This limitation is acknowledged, although representativeness is not pivotal in this qualitative study [48]. The sample obtained in this study represents a diverse selection of midwives, allowing multiple viewpoints to be analyzed and considered. This is seen as a strength in a qualitative study [40].

Conclusion

Overall, this study reveals that midwives view compassionate care as connecting with the patient so that they develop an individual understanding of the patient shown through action focused on care and support. Unique to this study was that midwives highlighted the importance of promoting advocacy while maintaining a non-judgemental attitude in attempting to develop an individualised understanding of the patient. It is recommended that further exploration be undertaken to develop an accepted conceptual definition of compassionate care in midwifery. The description of compassionate care as provided in this study could be used as an important starting point for future research investigating the concept in midwifery.

Abbreviations

HREC: Health Research Ethics Committee; ICM: International Confederation of Midwives; NWU: North-West University; SNS: Social Networking Site; WHO: World Health Organization

Competing interests

The authors declare no financial or any otherwise competing interests.

Authors’ contributions

SSK conducted the study; thematically analysed the data and wrote the preliminary manuscript for submission. CSM planned and designed the study, managed the ethical approval, initiated the data collection and is the principle investigator in a series of studies promoting kindness and compassion during childbirth. SKC made valuable contributions regarding the background of the study, assisted with thematically analysing the data and facilitated drafting the manuscript. All authors read and were in agreement with the final manuscript.

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SKC is an Associate Professor at the School of Nursing Science and NuMIQ research focus area of the North-West University.

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### Table 1 Responses for demographic data

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<thead>
<tr>
<th>Question</th>
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<tbody>
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</tr>
<tr>
<td></td>
<td>Female</td>
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</tr>
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<td></td>
<td>Urban area</td>
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<tr>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Other</td>
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<tr>
<td></td>
<td>30+ years</td>
<td>9</td>
</tr>
<tr>
<td>Is this the first time you are answering the survey?</td>
<td>Yes</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>10</td>
</tr>
</tbody>
</table>
Table 2 Identified themes and subthemes in kind and compassionate midwifery care

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making meaningful connections with patients</td>
<td>Displaying good interpersonal skills</td>
</tr>
<tr>
<td></td>
<td>Conduct based on dignity and respect</td>
</tr>
<tr>
<td></td>
<td>Establishing trust</td>
</tr>
<tr>
<td>Initiating individualised understanding of each patient</td>
<td>Showing empathy</td>
</tr>
<tr>
<td></td>
<td>Being patient</td>
</tr>
<tr>
<td></td>
<td>Prioritising maternal choice</td>
</tr>
<tr>
<td></td>
<td>Promotion of advocacy</td>
</tr>
<tr>
<td></td>
<td>Non-judgemental attitude</td>
</tr>
<tr>
<td>Action through care and support</td>
<td>Providing emotional support</td>
</tr>
<tr>
<td></td>
<td>Assistance through instrumental support</td>
</tr>
<tr>
<td></td>
<td>Continuous informational support</td>
</tr>
</tbody>
</table>
CHAPTER 4:
EVALUATION, LIMITATIONS AND RECOMMENDATIONS

4.1 Introduction

In this chapter the study is evaluated, the limitations of the study are discussed and future recommendations for nursing practice, nursing research, nursing education and policy are suggested.

4.2 Evaluation of the study

The objective of this study was to explore and describe the characteristics of kind and compassionate care during childbirth as these are perceived by midwives. The objective was accomplished through identification of themes and sub-themes that materialised in thematic analysis of the data. A qualitative descriptive research design was chosen for the study as best suited to the nature of the research problem (Creswell, 2009:18), namely a gap in knowledge about what midwives regard as the characteristics of kind and compassionate care. Few other empirical studies could be found exploring this relatively new concept (Ménage et al., 2017:558-562). The research design chosen also made it possible to explore and describe accounts from practice (Sandelowski, 1997:128), which was needed to develop a meaningful understanding of how midwives regard the concept of kind and compassionate care during childbirth. The characteristics of kind and compassionate care were identified as follows: (i) making meaningful connections with patients by displaying good interpersonal skills and showing dignity and respect, and establishing trust; (ii) initiating individualised understanding of each patient the midwife comes into contact with by showing empathy, being patient, permitting maternal choice, promotion of advocacy and having a non-judgmental attitude; and (iii) acting to provide care and support in the form of emotional support, instrumental support assistance, and continuous informational support.

A further aim of the study was to create awareness amongst midwives and promote kind and compassionate midwifery care during childbirth as this is believed to improve the quality of care rendered (Byrom & Downe, 2010:126, 135; Ménage et al., 2017:558-559 Nicholls & Webb, 2006:414, 427). This was achieved by creating the Facebook page named “Promoting kind and compassionate care during childbirth.” The Facebook page
was shared and liked by 81 midwives, encouraging discussion and awareness of the topic. Positive feedback, encouragement and praise was received from midwives on the Facebook page.

The findings of the study will be disseminated to the international scientific community by submitting them for publication in the *BMC Pregnancy and Childbirth* journal.

### 4.3 Limitations of the study

Few descriptions could be found in the literature regarding compassion in midwifery care. In the early stages of the study, this appeared to be a limitation. Yet as the study progressed it became a strength, as there is a definite gap in the literature in relation to the way midwives view compassion. This empirical study is able to contribute to the body of knowledge, as unique findings were identified, and provides a starting point for continued future investigations into the concept.

A limitation of the study was that only midwives with an active Facebook account were eligible for inclusion in the study. The sample may not be representative of all midwives, as it is not required of midwives that they have access to the internet or Facebook accounts (Callegaro *et al.*, 2015:18-23). This limitation is acknowledged, although representativeness is not pivotal in this qualitative study (Whitehead, 2007:782). The sample obtained in this study represents a diverse selection of midwives, allowing multiple viewpoints to be analyzed and considered. This is seen as a strength in a qualitative study (Creswell, 2009:173). Hill (1998:4) recommends a sample size of between 30 and 500 for an online survey. 98 completed responses were received and this was considered to be sufficient as data saturation took place.

### 4.4 Recommendations

The following recommendations are suggested by the researcher following completion of the study.

#### 4.4.1 Recommendations for midwifery practice

- A positive stance could be taken in practice by promoting kind and compassionate care during childbirth. This can be done by midwives starting initiatives advocating for kind and compassionate care in daily practice. For example, the unit manager of a
maternity ward could initiate and implement a ‘kind and compassionate employee of the month’ award to serve as encouragement to practice compassionately. An incentive could ultimately be offered to the overall winner after twelve consecutive months. A ceremony could be held where midwives could share stories of how they perceive kind and compassionate maternity care as this could improve understanding and awareness of kind and compassionate care during childbirth.

- The Facebook page could continue to be used as a platform for midwives to discuss kind and compassionate care during childbirth, as much encouragement and praise was received from midwives concerning the concept and initiative. If midwives who are currently practicing could improve the manner in which compassion is practiced and its incidence, the overall quality of midwifery care rendered could be improved.

- Focusing on the characteristics identified, the researcher could offer in-service training to local and other interested communities to make more midwives aware of what kind and compassionate care during childbirth is considered to be. To serve as continuous reminder to practice compassionately, posters could be put up around the ward summarising the characteristics of kind and compassionate care.

- A poster could be designed, highlighting the characteristics of kind and compassionate care during childbirth and shared electronically on the Facebook page. Midwives could be encouraged to spread the information and initiate discussions about the concept. In this way, the idea could be re-enforced in practice, as there would be an increased awareness amongst practicing midwives.

4.4.2 Recommendations for midwifery research

- The findings from this study will be incorporated into the main study by principle investigator Professor C.S. Minnie – “Promoting kind and compassionate care during childbirth” – in the development of a tool that will be used to assess kind and compassionate midwifery care in an effort to promote good midwifery care.

- More investigation is recommended into the concept of kind and compassionate care during childbirth from the midwife’s perspective to improve understanding of the concept within midwifery. Once the concept can be better defined and described, theoretical frameworks could be designed which could guide midwifery practice in
providing more compassionate care, ultimately improving the quality of midwifery care offered.

- Additional studies are needed in relation to the mother’s understanding of kind and compassionate care during childbirth.

4.4.3 Recommendations for midwifery education

- It is recommended that compassion be added to and taught in the undergraduate midwifery curriculum on a theoretical and practical level. On a theoretical level, articles could be shared regarding compassionate care and discussed from the first year of training through to graduation. Assignments and debate regarding the topic are encouraged amongst lecturers and students.

- A short course could be developed for midwifery lecturers, focusing on the characteristics of kind and compassionate care during childbirth.

4.4.4 Recommendations for policy

- A strategy plan for kind and compassionate care during childbirth could be developed for hospital management, nursing forums and policy makers. The findings of this study suggest that implementing policies promoting kind and compassionate care during childbirth could improve the quality of care given by midwives. The Department of Health could be approached to become involved and implement the policy in the North West Province, maternity units, as a pilot.

4.4.5 Recommendations for management

- The management of hospitals should create awareness concerning kind and compassionate care during childbirth in order to improve the quality of care provided by midwives. This could be done by implementing an in-service training program focusing on kind and compassionate care during childbirth.

- The management of hospitals could implement a personal and professional development system where feedback could be given to midwives regarding their behaviour concerning compassionate care. This could encourage the implementation of kind and compassionate care as a gold standard.
4.5 Conclusion

In this chapter, the study was evaluated, limitations in the study were identified, and recommendations for future midwifery practice, research, education, management and policy were made. The characteristics of kind and compassionate care during childbirth as perceived by midwives were identified as follows: making meaningful connections with patients; individualized understanding of each patient cared for during childbirth, and action through giving of care and support. Better understanding of how midwives perceive the concept is a starting point for design and development of potential frameworks which could be implemented in practice and which, in time, would improve the quality of care midwives offer to women during childbirth.
REFERENCE LIST


*Nursing Act* see South Africa.


*Protection of Personal Information Act (POPI)* see South Africa.


Strauss, C., Taylor, B.L., Gu, J., Kuyken, W., Baer, R., Jones, F. & Cavanagh, K. 2016. What is compassion and how can we measure it? Clinical psychology review, 47:15-27.


APPENDIX A – SURVEY QUESTIONS

Demographic section. This information is needed to publish in Scientific Journals. All answers will be kept anonymous.

Please click the appropriate box:

<table>
<thead>
<tr>
<th>How old are you?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>21-29 years old</td>
<td></td>
</tr>
<tr>
<td>30-39 years old</td>
<td></td>
</tr>
<tr>
<td>40-49 years old</td>
<td></td>
</tr>
<tr>
<td>59-60 years old</td>
<td></td>
</tr>
<tr>
<td>60 + years old</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your gender?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where do you practice midwifery?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural area</td>
<td></td>
</tr>
<tr>
<td>Urban area</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In which facility do you practice midwifery?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State Hospital</td>
<td></td>
</tr>
<tr>
<td>Private Hospital</td>
<td></td>
</tr>
<tr>
<td>Community Health Centre</td>
<td></td>
</tr>
<tr>
<td>Private Practice (Midwife lead)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many years experience do you have of working as a midwife?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 years</td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td></td>
</tr>
<tr>
<td>11-20 years</td>
<td></td>
</tr>
</tbody>
</table>
Is this the first time you are answering the survey?

Yes [ ] No [ ]

Please write a paragraph about an instance in which you saw or experienced kind and compassionate care during childbirth

List five words that you associate with kind and compassionate care during childbirth

Additional comments
Survey regarding characteristics of kind and compassionate care during childbirth according to midwives

You are hereby invited to participate in a research project to identify the characteristics of kind and compassionate maternity care according to midwives. This is part of a research project on promoting kind and compassionate care of which Prof Karin Minnie of INSINQ Research Focus Area of the North-West University is the primary investigator. This part of the project will add to the knowledge needed to identify an instrument that can be used to assess the maternity care in selected health care facilities, which can eventually contribute to the promotion of kind and compassionate maternity care.

You will be eligible to participate if you are

- a midwife who can make a contribution from your experience.

Your decision to participate or not is entirely voluntary and you can stop at any stage if you do not want to continue.

If you decide to participate you are expected to complete a few demographic questions and two survey questions on the next page. In the first question you will be asked to write a paragraph about an instance which you saw or experience that portray kind and compassionate maternity care. In the second question you are asked to list five words that you associate with kind and compassionate maternity care. You are also welcome to leave further comments. You can complete the survey more than once. The completion of the survey are not expected to take more than 15 minutes. There is no direct benefit for you in participating, but your participation can contribute to guidelines to promote kind and compassionate care provided to new mothers. This is a low risk study, but if you experience any psychological distress, you are welcome to contact the researcher at the e-mail address below for assistance or referral.

The answers to the questions cannot be accessed by anyone but the research team. The completed surveys will be kept safely on servers that are well protected with passwords and firewalls.
All the answers will be analysed together and only the combined findings will be used in the final report. You are welcome to send an e-mail to Samantha.Krause@nwu.ac.za if you would like to receive an electronic version of this report or have any questions.

Please click on the button if you are eighteen years or older.

Please click on the button if you understand the information about the research.

Please click on the button if you want to complete the survey.
APPENDIX C – ETHICS APPROVAL FROM NORTH-WEST UNIVERSITY

ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by Health Research Ethics Committee (HREC), after being reviewed at the meeting held on 13/07/2016, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby approves your study as indicated below. This implies that the NWU-IRERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Promoting kind and compassionate care during childbirth.

Study Leader/Supervisor: Prof CS Minnie
Student: 

Ethics number: NWU-06972-16-A1

Application Type: Single study
Commencement date: 2016-08-28

Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation up to a maximum period of three years.

Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC [if applicable].
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC.
- Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The study leader/principle investigator must report in the prescribed format to the NWU-IRERC via HREC:
  - annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study;
  - without any delay in case of any adverse event or incident (or any matter that intimates sound ethical principles) during the course of the study.
- Annually, a number of studies may be randomly selected for an external audit.
- The approval applies strictly to the proposal as stipulated in the application form. Should any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of those amendments at the HREC, prior to implementation. Should there be deviation from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the study may be started.
- In the event of ethical responsibility, the NWU-IRERC and HREC retain the right to:
  - restrict access to any information or data at any time during the course of the study;
  - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;
  - withdraw or postpone approval:
    - if unethical principles or practices of the study are revealed or suspected;
    - if it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented, the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately;
    - if new institutional rules, national legislation or international conventions deem it necessary.

HREC can be contacted for further information or any report template via Ethics-HREC@nwu.ac.za or (018) 289 1206.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the IRERC or HREC for any further enquiries or requests for assistance.

Yours sincerely,

Prof LA Du Plessis (Digitally signed by Prof LA Du Plessis)
Date: 2016.08.05 17:27:31 +0200

Prof Linda du Plessis
Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)
29 May 2018

To whom it may concern

This is to certify that the Master’s thesis entitled “The characteristics of kind and compassionate care during childbirth according to midwives” by Samantha Krausé has been edited by me for English grammar, idiom, orthography, punctuation and sentence structure.

I will be happy to furnish additional information if requested.

David Newmarch BA(Hons) (Natal), M Phil (York)
ADDENDUM A - PROMOTING KIND AND COMPASSIONATE CARE
FACEBOOK PAGE SCREENSHOT
ADDENDUM B – EXAMPLE OF POST ON FACEBOOK PAGE INVITING POTENTIAL PARTICIPANTS TO PARTAKE IN THE STUDY

Promoting kind and compassionate care during childbirth
13 Dec 2016 at 11:45 • 🤗

You are hereby invited to participate in a research project to identify the characteristics of kind and compassionate care during childbirth according to midwives.

Click on the link below to take part now:
https://www.surveymonkey.com/r/CSFYSKQ

9 Shares